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**The Review of the HIV/STD
Program of the
Health Sector II
Project**
(Project No. 522-0216)

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AIDSCAP	AIDS Control and Prevention Project
AID/W	Agency for International Development/Washington
BCC	Behavior Change Communication
CA	Cooperative Agreement
CCAP	Title of the survey conducted by AIDSCAP: Conocimientos, Creencias, Actitudes y Practicas de Sexualidad y ETS/VIH/SIDA
CCC	Central Coordinating Committee
CDC	Centers for Disease Control and Prevention
CEDEPS	"Centro de Estudio para el Desarrollo y Participación Social" (CEDEPS Center for Studies on Development and Social Mobilization, Comayagua)
CESAMO	Centro de Salud Municipa Médico
CGS	Comunidad Gay Sanpedrana, an NGO
CO	Country Office
COCSIDA	"Centro de Orientación y Capacitación en SIDA" (COCSIDA Center for Orientation and Training in AIDS, La Ceiba)
COHEP	The Honduran Council for Private Enterprise
COMSIDA	The National AIDS Commission
COMVIDA	"Comunicación y Vida" (COMVIDA Communication and Life, with the Municipality of San Pedro Sula)
CONALSIDA	The High Commission on the Fight Against AIDS
CPI	Country Program Indicator
CTO	Cognizant Technical Officer
CY	Contract Year
EFHS	Epidemiology and Family Health Survey
EOP	end of project
FHI	Family Health International
FHI/NC	Family Health International/North Carolina
FOM	Field Operations Manual
FSLs	"Fraternidad Sampedrana de la lucha contra el SIDA" (FRATERNIDAD the San Pedro Sula Brotherhood in the Fight Against AIDS) (AIDSCAP supported)
FY	Fiscal Year
GC	Gonococcus, or Neisseria gonorrhoeae
GNP	Gross National Product
GTZ	German Agency for International Cooperation (Deutsche Gesellschaft für Technische Zusammenarbeit GmbH)
HIV	Human Immunodeficiency Virus
HSII	Health Sector II
HTS	Health Technical Services

HQ	AIDSCAP Headquarters Office, Arlington, VA
IA	Implementing Agency
ICC	Interagency Coordinating Committee
IEC	Information, Education and Communication
IHSS	Instituto Hondureño de Seguro Social
IVDU	Intravenous Drug Users
JNBS	Junta Nacional de Bienestar Familiar
KAP	Knowledge-Attitudes-Practices
LAC	Latin American and Caribbean Region
LACRO	Latin American Regional Office
LOP	Life of Project
MIS	Management Information System
MOH	Ministry of Health
MSM	Men who have sex with men
NACP	National AIDS Control Program
NGO	Non-Governmental Organization
ODECO	Organización de Desarrollo Comunitario
OFRANEH	Organización Fraternal Negra Hondureña
ONUSIDA	The Joint United Nations Programme on HIV/AIDS
OYB	Operational Year Budget
PAHO	Pan American Health Organization
PASCA	The Central American AIDS Action Project (Proyecto Acción Sida Centro América)
PETSIDA	Programa de Educación en Enfermedades de Transmisión Sexual y VIH/SIDA para la clase trabajadora en Honduras
PIO/T	Project Implementation Order/Technical Services
PPS	population proportional to size
PRODIM	Proyecto Desarrollo Integral de Mujer
PROPRE	Programa de Prevención VIH/SIDA/ETS
PVO	Private Voluntary Organization
R4	Results Review Resources Request
RA	Resident Advisor
RPR	Rapid Plasma Reagin (see VDRL/RPR below)
SOW	Scope of Work
SPS	San Pedro Sula
STD	Sexually Transmitted Disease
TA	Technical Assistance
UMIET	Unit for Integrated Management of STDs
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
U.S.	United States
USAID	United States Agency for International Development
VDRL/RPR	Venereal Disease Research Laboratory/Rapid Plasma ReaginTest Two tests for syphilis
WHO/GPA	World Health Organization's Global Programme on AIDS

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Preface

The Review of the HIV/STD Program of the Health Sector II Project (Project No. 522-0216), was carried out at the request of the Office of Human Resources Development, USAID/Honduras. The evaluation was conducted during the period August 12, 1995, through September 11, 1996, in Honduras by a team of multidisciplinary professionals.

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The team also wishes to thank USAID/Honduras especially during a very busy time for the Mission, and the Health Technical Services Project, for their thorough preparation and support during the evaluation activities.

Finally, the team thanks Mrs. Aura Napier-Gegg, Administrator of the Asociación Copán, our bilingual secretary and financial officer, for her indefatigable support and good humor during this period of intense activity.

Finally, this evaluation is dedicated to Kati and Lori, three-year-old seropositive twins we met in rural Honduras. Unrecorded in official statistics, and unrecognized in their village, they are engraved in our minds.

Executive Summary

USAID/Honduras requested a program review of its STD/HIV Program Intermediate Result **3.3: Increased Use of STD/AIDS Prevention Practices**. Intermediate result 3.3 is a subcomponent of Strategic Objective No. 3, Improved Family Health, of the Mission's Results Review Resources Request (R4) plan. The projects included under the intermediate result are: LAC Central American HIV/AIDS (596-0179), which supports the Central American AIDS Action Project (PASCA); Central Contraceptive Procurement (936-3057); Technical Advisors in AIDS and Child Survival (936-5970); and the AIDS Technical Support Project—AIDS Control and Prevention (AIDSCAP) (936-5972). This program review focused almost exclusively on the AIDSCAP Project and on surveillance and STD activities, discussing only peripherally the other projects involved in achieving this intermediate result. This focus is derived from the questions provided to the team by the Mission before the evaluation, and the need to make a number of urgent decisions concerning the extension of the AIDSCAP project to 1999. In order to respond to this need, Health Technical Services (HTS) fielded a three-person team in August 1996. The team consisted of:

- Dr. Carl Kendall, Team Leader
- Dr. Bernard Branson, Epidemiologist (STD/Surveillance Specialist)
- Lic. Juan Jacobo Hernandez, NGO Specialist

The Mission supplied the team with a scope of work and 40 questions (Questions and Answers included as Annex 1). This scope was expanded to include recommendations to assist the Mission in developing a long-term strategy for the period 1999-2003.

The team leader and epidemiologist arrived in Honduras on August 12, met with USAID/Honduras, and initiated site visits. The following week the team was joined by the NGO specialist. The team epidemiologist and NGO specialist spent two weeks on site, and the Team Leader spent four weeks. The evaluation methodology involved a review of documents and databases, as well as interviews with staff of AIDSCAP, the Mission, the Ministry of Health, Implementing Agencies (IAs), and other interested parties.

I. Current Epidemiological Situation

A. HIV Surveillance

1. AIDS Cases. Through May 1996, 5,286 cases of AIDS have been reported in Honduras. An additional 1,014 persons with AIDS-related complex (ARC), and 1,765 asymptomatic HIV positive persons have also been reported. In the first five months of 1996, 464 cases have been reported. If annualized, this would amount to 1,114 cases, the largest number of cases ever reported in Honduras in a single year.

2. HIV Infection. Available data indicate that the levels of HIV infection remain high in high risk and general populations, but do not reflect an explosive increase from previous years. Data from blood donors suggest an HIV prevalence of 0.5-1 percent in the general population, with higher rates noted in San Pedro Sula. Prevalence among antenatal mothers in Tegucigalpa has increased from 0.3 percent in 1992 to 1.03 percent in 1996; in San Pedro Sula, it is reported to have remained stable at about four percent. The 1995 survey of commercial sex workers (CSWs) in San Pedro Sula (conducted in November-December) indicates an HIV prevalence of 20.5 percent, a substantial increase from 12.1 percent in 1994. No recent HIV prevalence information is available for men, men who have sex with men (MSM), or the Garífuna¹.

B. STD Surveillance

The Honduran Ministry of Health (MOH) continues to report declining levels of syphilis and gonorrhea. Sentinel surveillance among antenatal mothers in San Pedro Sula and Tegucigalpa reflects low levels of syphilis in antenatal mothers, and a substantial decline among CSWs in San Pedro Sula. (No data are available from Tegucigalpa.) The reported levels (1%) are so low as to be unbelievable, in view of the observed HIV prevalence. Syphilis seroprevalence was reported to be 20 percent among CSWs in a special study of commercial sex workers conducted by Dr. Cesar Nuñez, staff epidemiologist with the STD/AIDS Division, suggesting that sentinel surveillance data are unreliable. General antenatal screening for syphilis, though a national standard, is inconsistent; it appears to reach only 35-50 percent of pregnant women. Reagent shortages and difficulty with specimen transport and preservation are frequently cited as the reasons for the low rates of screening.

¹Formerly known as Black Caribs, a people descended from escaped African-Caribbean slaves and Carib Indians.

C. STD Treatment

The following progress has occurred in the area of STD treatment:

- With AIDSCAP support, country norms and guidelines for syndromic STD management have been developed.
- During this evaluation, training for 32 health care workers from the health regions in the four project areas was conducted.
- The MOH has planned for a supply of the necessary drugs through a World Bank project, but these drugs are not yet available in the clinics.
- AIDSCAP has initiated a study to determine antibiotic susceptibilities of STD pathogens in Honduras, but specimen collection has been slower than expected, and no results are available as of this date.

D. Syndromic Management

Syndromic management will be piloted in the four STD Integrated Management Units (UMIETS). It is planned that these will then serve as training resources for persons in area health centers. The four UMIETS have been refurbished, and laboratory capabilities upgraded. CSWs are the primary focus for these clinics, many of whom are currently receiving STD care at Centro de Salud Municipa Médicos (CESAMOs) under the program of "control."

The Honduran social security health system (IHSS) has not been involved in the process of introducing syndromic treatment, uses a different set of treatment guidelines, and does not have access to the drugs necessary for syndromic treatment. This appears to be a particular problem in San Pedro Sula, where IHSS is the care provider to a significant proportion of the population susceptible to STD and HIV. The IHSS hospital in San Pedro Sula received AIDSCAP support for strengthening its laboratory, but the planned STD clinic has not been developed.

II. Programmatic Issues

A. Honduran Ministry of Health STD/AIDS Division

The STD/AIDS Division was established in 1994, combining the MOH's STD Control and Prevention Program and the National AIDS Control Program, which was founded in 1992. USAID's coordination with the program is through a Central Coordinating Committee which includes the Director of the MOH program, the AIDSCAP Country Director, and Dr. David Losk, USAID Health Officer. This coordination is effective, but is an operational rather than a policy level coordination.

The Division has a broad mandate and shrinking staff. Among its responsibilities are support to the Health Regions, developing and promulgating norms for STD treatment, surveillance, condom logistics, and health education.

Surveillance is not currently being conducted, however, and although norms have been developed for the syndromic therapy treatment regimen and the first *tranche* of Ministry personnel has been trained with AIDSCAP support, continued high levels of support from AIDSCAP will be required. In addition, the Medium Term Plan developed jointly by the Ministry with the Pan American Health Organization (PAHO), World Health Organization's Global Programme on AIDS (WHO/GPA), and which served as a blueprint for the program, is ending. This may come at an opportune moment because currently the international donor community for HIV/AIDS prevention is at a crossroads, and there is a lack of direction among the donors. AIDSCAP and the Ministry have been a motivating force in directing program efforts and should continue to do so. USAID support can play a crucial role in focusing efforts in a productive fashion.

Health education efforts of the MOH have focused on awareness messages directed at the general population, and on information or an awareness in general (e.g., PETSIDA²). Many of these messages are ambiguous as to intent, and most are not actionable. They may serve a purpose in reminding people of the continuing epidemic, but are unlikely to bring about behavior change.

For these efforts to be successful in promoting condom use, for example, one would have to assume that awareness and knowledge levels are low, that other barriers to condom use have been overcome, and that condoms are accessible. All these assumptions are suspect. AIDSCAP has been assisting the project to adopt a behavior change communication perspective and should continue to do so, but it will need help.

B. AIDSCAP

The USAID Mission in Honduras joined the global AIDSCAP project relatively late in that project's cycle (1991-1996). Although the global AIDSCAP project was due to end August 1996, the Mission delivery order was signed February 8, 1995, and project activities in Honduras were not really initiated until June 1995. Thus, the project has been in existence for a total of 15 months. At the same time, as part of planning the new Health Sector II (HSII) extension in Honduras, the Mission fully intended to fund the project for four years, until the termination of the HSII project. Thus, for the purpose of the evaluation, several dates are relevant. First, the

²Programa de Educación en Enfermedades de Transmisión Sexual y VIH/SIDA para la clase trabajadora en Honduras

global AIDSCAP end of project (EOP) of August 1997, and the HSII EOP of September 1999. By August 1997, the project must make the transition to a free standing local Honduran private voluntary organization (PVO). By September 1999, all HSII project funding will end.

The first year of the project has been very successful. NGOs have been identified and trained, and financial and administrative reporting is in place guaranteeing the appropriate use of project funds. STD norms, treatment guidelines, and training materials have been developed with the Ministry and training is underway. Both quantitative and qualitative research has been conducted which will produce data to develop communication interventions by the NGOs. Developing, funding, and monitoring of the ten subagreements with the IAs is an enormous achievement. USAID through support to AIDSCAP is one of the only donors in-country that actually closely monitors each sub-project. AIDSCAP has maintained excellent working relationships with the Ministry, USAID, and other donors. The Ministry and other donors perceive AIDSCAP to be an essential element in their response to the epidemic.

C. NGOs

The NGOs report having been strengthened by the AIDSCAP project, and are overwhelmingly supportive of AIDSCAP's efforts. With the exception of Organización Fraternal Negra Hondureña (OFRANEH), whose activities are currently frozen due to financial irregularities, all sub-projects appear to be responsive to project guidelines and intent upon moving to the intervention stage. It is recommended that all NGO sub-projects be continued for at least the next year.

The NGOs selected by the project demonstrate varied strengths in the areas identified for intervention. For example, one NGO may have strong relations with one of the target populations, or another may have staff with strong health education skills. To date, however, all of the NGOs have been involved in all activities, such as developing health education materials for the different target groups. AIDSCAP should be permitted to build on strengths and selectively develop the NGOs. The strategies, approaches, and materials developed could then be shared across the NGOs.

NGOs have requested closer supervision and support from AIDSCAP, and have recommended that a satellite AIDSCAP office be created on the North Coast of Honduras. This is a good suggestion and thought should be given to either moving staff to the North Coast or recruiting an additional staff person to provide support to projects in San Pedro Sula (SPS) and La Ceiba.

III. Summary and Recommendations

Recommendations for the Mission:

1. The Mission needs to revise its indicators for HIV/AIDS prevention. The recommended indicators are:
 - 3.E Seroprevalence in CSWs in the San Pedro Sula UMIET and in women attending the antenatal clinic in Catarina Rivas Hospital in San Pedro Sula.
 - 3.3b Increased rate of condom use in most recent act of sexual intercourse defined as "at-risk."
 - 3.3d Increased proportion of health facilities in project areas assessing and treating STDs syndromically.
2. The Mission needs to coordinate support from other resources to assist AIDSCAP to achieve these new targets:
 - a. In order to resolve issues with current surveillance activities, a consultant should be identified immediately to review the available data, data collection procedures, and to guarantee that all equipment and reagents are available so that 1996 data can be collected in November and December. The Mission should take advantage of Centers for Disease Control and Prevention (CDC) resources to review and improve surveillance activities.
 - b. The regional PASCA project can provide training and support to the NGOs.
 - c. A regional social marketing of condoms project can also assist the project to achieve its targets.
 - d. Finally, a mechanism for routine coordination of donors and senior Ministry staff for STD/HIV/AIDS is recommended. Regular meetings should be convened with Dr. Enrique Zelaya, Director General of the Ministry responsible for the STD/HIV/AIDS Division; other Ministry staff; AIDSCAP; and USAID.
3. In collaboration with AIDSCAP/Honduras, the Mission needs to develop a new annual work plan for the entire period of October 1, 1996 - August 31, 1997 (one month before the end of the worldwide contract). AIDSCAP/Washington (AIDSCAP/W) is requesting that all field offices terminate all sub-projects by April 30, 1997, and all offices to close by June 30, 1997. AIDSCAP/W is providing a one month cushion for these dates. Still, this will present an unfortunate gap in the project. The Mission has already extended the Honduras delivery order through September 1997.

4. The Mission also needs to intervene with AIDSCAP/W to reduce end of (central) project closeout activities.

Recommendations for AIDSCAP:

1. AIDSCAP has had a very successful launch in Honduras. Three substantive areas are foci of the project and warrant continued strengthening. These are:

- Surveillance
- Syndromic STD Treatment
- Behavior Change Communication

Technical Assistance (TA) will continue to be required in all three areas. This TA should be carefully selected to provide continuity for the project and NGOs through the entire life of the project.

2. In order to achieve project results, AIDSCAP must support the Ministry of Health's Division of STD/AIDS. Two actions are recommended: 1) assist the Ministry to develop a new Medium Term Plan this fall; and 2) provide long-term technical, on-site support.
3. The local AIDSCAP entity needs to make the transition to direct Mission support for 1997 - 1999. This involves several actions for AIDSCAP:
 - AIDSCAP/Honduras needs to become a registered Honduran PVO as quickly as possible, so that USAID can continue to fund the project for an additional two years, and so that there is no gap in support;
 - Due to the transition to the longer-term, four-year project, AIDSCAP/Honduras needs to develop new indicators and a plan for the remaining three years. For 1996-97 they should develop a detailed one year work plan;
 - To measure impact, Knowledge-Attitudes-Practices (KAP) surveys were proposed for 1997. These need not and should not be conducted now. New evaluation plans need to be developed.
 - NGO subcontracts were written within the guidelines of the old logframe indicators. These need to be modified.
4. USAID/Washington (USAID/W) and AIDSCAP/W should reduce the reporting obligations for end of project and end of contract activities. Given the new results framework, some obligations included in the work plans should be dropped and new benchmarks developed.
5. The new approach and results framework will require some reprogramming of project activities. Although wholesale changes in NGOs, target groups, or strategies are not

recommended in the next year of the project, the new indicators and results orientation and expectations for 1998 impact require that project activities give emphasis to:

- Syndromic management of STDs and improving health seeking behavior for STDs in the Project's area of influence: Health Regions Metro, 2, 3, and 6;
 - Improved surveillance in the four Regions; and
 - Behavior Change Communication, both in assisting the MOH at the national level, in the four project Regions, and in the project NGOs.
6. Behavior change efforts should now focus on careful development of communication interventions. These should not be rushed. The qualitative data provided by the surveys conducted in 1996 and the results of the KAP surveys provide an important resource for intervention design. As soon as possible, these data should be reviewed by an experienced qualitative researcher with experience in HIV/STD behavioral change communication intervention design. In a workshop with the IAs these data can be reviewed and used in intervention strategy development and design.
 7. NGOs and IAs will continue to need close monitoring and support. Many are located on the North Coast in San Pedro Sula and La Ceiba. An AIDSCAP staff person should be hired or moved to a satellite office in San Pedro Sula to provide this support.

Long-term Recommendations:

1. Population-based HIV/STD seroprevalence studies and behavioral research need to be conducted in high risk groups such as CSWs, MSM, Garífuna, and other groups that might be identified. With respect to behavioral research, very little is known about the sexual practices glossed as bisexuality, and whether they play a role in the epidemic. If they do, the people who practice them may prove extremely difficult to reach, and research should be conducted to test pilot interventions. In general, these special studies will be important for measuring program impact and for design of future interventions.
2. Interventions to reduce vertical transmission, such as the use of AZT or other antiviral drugs, and improved delivery for seropositive mothers should become part of the HIV/AIDS prevention program.
3. Current Honduran national policies related to decentralization of the state involve municipalities in developing health interventions, including HIV. A wide range of prevention interventions for the general public involving the municipalities, communities, schools, and other local civic organizations throughout Honduras need to be developed. Implementing this policy will be an important challenge.

1. Introduction

USAID/Honduras requested a program review of its STD/HIV Program Intermediate Result **3.3: Increased Use of STD/AIDS Prevention Practices**. Intermediate result 3.3 is a subcomponent of Strategic Objective No. 3, Improved Family Health, of the Mission's R4 plan. The projects included under the Intermediate result are: LAC Central American HIV/AIDS (596-0179), which supports PASCA; Central Contraceptive Procurement (936-3057); Technical Advisors in AIDS and Child Survival (936-5970); and the AIDS Technical Support Project—AIDS Control and Prevention (AIDSCAP) (936-5972). This program review focused almost exclusively on the AIDSCAP Project and on surveillance and STD activities, discussing only peripherally the other projects involved in achieving this intermediate result. This focus is derived from the questions provided to the team by the Mission before the evaluation, and the need to make a number of urgent decisions concerning the extension of the AIDSCAP project to 1999. In order to respond to this need, Health Technical Services (HTS) fielded a three-person team in August 1996. The team consisted of:

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A draft copy of the evaluation was left on-site with the Ministry, USAID, and AIDSCAP. Comments were collected and forwarded to HTS. The evaluation was modified in light of these comments and presented to the Mission October 1996.

2. Background

Honduras is located in the middle of the Central American isthmus and is the second largest of the region's countries. It shares borders with Guatemala and El Salvador to the west, and with Nicaragua to the east. The country is divided into 18 departments (provinces) and 293 municipalities, and organized into nine "Sanitary Regions" (public health administrative subdivisions).

Covering 112,492 km², Honduras had an estimated population of 5.7 million in 1995 and an average annual population growth of 2.7 percent. According to the 1974 census, the rural population represented 68.6 percent of the total, decreasing to 58.3 percent by 1988. This process of urbanization has continued. The urban population is concentrated in two cities, San Pedro Sula and Tegucigalpa. San Pedro Sula, the industrial capital of the country, has approximately 800,000 inhabitants. Tegucigalpa, the political capital, is centrally situated and is estimated to have more than 1,000,000 inhabitants.

Honduras' annual per capita income and the standard of living are among the lowest in the Western Hemisphere. Per capita GNP in 1994 was US\$593. Per capita GNP is not evenly distributed, however, and the program's and AIDSCAP's resources are focused in the "Central Corridor of Development" which runs roughly between Tegucigalpa, San Pedro Sula, and the North Coast. The "corridor" includes the main urban centers of Tegucigalpa, San Pedro Sula, and La Ceiba. Migrants from less developed rural areas are drawn to the economic opportunities offered in the Central Corridor creating, as in other parts of the world, the conditions for transmission of HIV. According to official figures in 1988, 70 percent of the country's population live in this area.

A. The First Years of the Epidemic

Despite having only 17 percent of Central America's population, Honduras reported 57 percent of all cases of AIDS in the region in 1995. The annual incidence of AIDS cases increased from under 50 per million persons in the 1980s to 150.7 per million in 1992, and to 188.1 per million in 1993. In addition to difficulties with testing and reporting discussed below, Sierra et. al. (See Bibliography-Annex 3) consider that the stigma and discrimination associated with HIV infection and disease have also discouraged people from seeking testing and, thus, the reported rates are significantly below their real levels. Sierra et. al. report that the beliefs expressed by

some health care workers and HIV infected persons are that "the health care system has so little to offer HIV infected patients, it makes no difference to look for help," and that "people have become afraid to be diagnosed and avoid the health care system."³

The first case of AIDS in Honduras allegedly occurred in 1984, although a positive diagnosis from North American labs was not made until 1985. In 1992, Bú et. al. (See Bibliography, Annex 3) described the first reported 100 cases of AIDS in Honduras. The male-to-female ratio was nearly 2-to-1 (66 men-to-34 women), although this proportion has moved closer to unity over time. Sixty-one of the heterosexual individuals in this study reported having had multiple sex partners. Eleven CSWs and two IV drug users were in this group. Eighteen persons identified themselves as homosexual and 15 as bisexual. Blood transfusion was the only risk factor reported in one case, and two cases of vertical transmission from mother to child were reported. Among the 90 individuals with known residences, 67 lived in the northern coastal area of the country (34 of them in San Pedro Sula).

The population most affected by AIDS in Honduras is that between 20 to 39 years of age, with approximately 65 percent of all cases since the beginning of the epidemic falling into this age group. One-third of the cases have occurred in 15- to 24-year-olds. For most of the age groups there have been no differences in the distribution of cases over time. The exception is for the population under five. From 1985 to 1990 the number of cases reported in the under-five group was 26, representing just 2.2 percent of all reported cases. During the years 1991 to 1996 this percentage increased to 5.1 percent (216 cases), a reflection of the increased number of HIV infections in women.

Because the male-to-female ratio is approaching unity, Honduras' profile of the HIV epidemic has differed from the rest of Central America. It is clear that heterosexual transmission plays a central role in the epidemic, and that vertical (i.e., mother-to-child transmission) accounts for a relatively large number of cases of AIDS. As Sierra et. al. report, "For all of the cases reported as of April 1996 transmission has been through the following means: heterosexual 82%, homosexual 3.5%, male bisexual 6.5%, perinatal 4.7%, blood transfusions 0.8%, and IV drug abuse 0.1%. Analysis of the distribution of cases among risk groups indicates that heterosexual transmission increased dramatically during the first seven years of the epidemic, only leveling off in the last four years. The homosexual and bisexual groups combined represented approximately ten percent of all reported cases and demonstrated similar patterns throughout the epidemic. From 1985 to 1989 their incidence rates increased rapidly, but have shown a moderate tendency to level since 1990."⁴

³Sierra, et. al., p. 8.

⁴Sierra, et. al., p.8.

AIDS cases in Honduras are not evenly distributed—cases are concentrated in the central corridor of development which includes the main urban and economic centers of the country. Using 1995 case reporting figures, as Sierra et al. report, “Forty-nine percent (2,565 of the cumulative total) have been reported from Region 3 and 19.4% (1,016) from the Metropolitan Region. Approximately 58% of all cases in the country are reported from the northern part of the country (Regions 3 and 6). The departments of Francisco Morazán [Tegucigalpa] and Cortés [San Pedro Sula] have the highest number of cumulative cases and the highest AIDS incidence for 1995.”⁵

In February 1995, the MOH conducted a modeling exercise with the assistance of AIDSCAP/Washington. The resulting document, “El impacto socioeconómico del VIH/SIDA en Tegucigalpa y San Pedro Sula, Honduras” (Nuñez, Cesar A., Mario Flores, Steven Forsythe and Michael Sweat, February 1995), had a large impact on Ministry and USAID program planning. The modeling exercise predicted two outcomes for the year 2000: a high estimate and a low estimate. The high estimate predicted general population prevalence of HIV at 17 percent in San Pedro Sula, and 12 percent in Tegucigalpa, with low estimates of 10 percent and 3.5 percent, respectively. A number of assumptions about the parameters of the model were made, of course, since so little information is actually available about transmission characteristics. Additionally, the model adopts epidemic curves (gammas) and their assumptions based on epidemics elsewhere in the world. Although this evaluation did not review this exercise, the opinion of most local experts is that the high estimates, and even the low estimate in San Pedro Sula, may be too high. This makes program planning difficult, and raises expectations for reported numbers of new cases that are not reported. These unfulfilled expectations reduce public and ministerial demand for the program.

This document recommends the development of a new Medium Term Plan (see below). As a part of that exercise the evaluation team recommends a review of anticipated seroprevalence levels. While not calling for a complete modeling exercise, expertise should be brought to bear to identify reasonable outcomes for program planning.

B. The Response

1. Sexually Transmitted Disease Control and Prevention Program

Surveillance for syphilis and gonorrhea is based on a passive collection of routine data from health centers and laboratories in the country. The fluctuating pattern observed in the number of

⁵Sierra, et. al., p.8.

reported cases of gonorrhea (GC) and the percentage of positive screening tests for syphilis (VDRL/RPR⁶) reflect the tremendous irregularities and failures in the surveillance system to detect cases.

Clinical management of STD cases has been assigned to specialized STD clinics in health centers (UMIETs). These STD services are heavily stigmatized for their treatment of CSWs and homosexuals. Sierra et. al. report that in a 1992 study one of every three patients attended by a doctor in the clinics received adequate medical attention. The same study reported that only about half of the patients received a sufficient number of condoms and adequate information on STD prevention.

Sierra et. al. report that common problems observed in their field visits to STD clinics in Regions 2, 3, 6, and in the Metropolitan Region included: elevated demand for services over the last few years; lack of training and supervision of personnel; lack of norms and procedures for STD treatment; lack of reliable laboratory support for diagnosis; lack of a continuous supply of materials (medicines, gloves and reagents); and finally, low motivation of personnel.

a. Response

The STD/AIDS Division of the Ministry of Health (MOH) was established in 1994, combining the MOH's STD Control and Prevention Program and the National AIDS Control Program, founded in 1992. Ministry activities before the development of the Division were coordinated through several intersectoral committees: "La Comisión de SIDA" (COMSIDA, the AIDS Committee), and "La Comisión de Alto Nivel de Lucha Contra el SIDA" (CONALSIDA, the High Commission on the Fight Against AIDS), established in 1988. Both of these committees met irregularly and ceased operation in 1993.

USAID's coordination with the program is through a Central Coordinating Committee (CCC) which includes the Director of the MOH program, the AIDSCAP Country Director, and Dr. David Losk, USAID Health Officer.

⁶Nontreponemal tests are used to screen patients for the presence of nonspecific reagin antibodies that appear and rise in titer following infection. Although VDRL (Venereal Disease Research Laboratory) and RPR (rapid plasma reagin) are the most commonly used nontreponemal tests, others are available. The sensitivity of nontreponemal tests varies with the levels of antibodies present during the stages of disease. In early primary syphilis, when antibody levels may be too low to detect, results may be nonreactive, and the sensitivity of nontreponemal tests is 62-76%. Antibody levels rise as disease progresses; titers usually peak during secondary syphilis, when the sensitivity of nontreponemal tests approaches 100%. In late syphilis, titers decline, and previously reactive results revert to nonreactive in 25% of patients; in untreated late syphilis, test sensitivity averages only 70%. Nontreponemal test titers decline or revert to normal after successful treatment.

The CCC is an effective committee, but has limited access to higher levels in the MOH, and no contact with other donors. Mechanisms need to be developed to grant regular access to the AIDSCAP Country Director to senior level MOH staff, and to coordinate donor efforts. The new Medium Term Plan might recommend such mechanisms.

The STD/AIDS Division followed the objectives and strategies designed by the World Health Organization's Global Programme on AIDS (WHO/GPA) and its Medium Term Plan. The stated objectives of the STD/AIDS Division are rather general:

- Prevent STDs and HIV infection
- Diminish the impact of HIV/AIDS and other STDs
- Reduce social discrimination and promote respect and awareness of human rights and human dignity
- Mobilize and unify the efforts of national and international resources in the fight against HIV/AIDS

The strategies designated by the STD/AIDS Division to achieve these objectives include:

- Strategy 1: Decrease the dissemination of HIV transmitted via sexual, perinatal, and blood transfusion routes.
- Strategy 2: Ensure access to health care services and give adequate attention to individuals with HIV infection, AIDS, or STDs.
- Strategy 3: Promote, coordinate, and develop specific actions required for the elimination of congenital syphilis.
- Strategy 4: Facilitate equitable, effective, and efficient access to information and education on health and STD/HIV/AIDS to the general population and to target groups.
- Strategy 5: Promote and facilitate social participation and community-based action in the fight against STD/HIV/AIDS and in general health promotion.
- Strategy 6: Promote the revision and implementation of current laws to protect the rights of infected individuals in society.
- Strategy 7: Facilitate and guide international cooperation according to national health policy in the fight against STD/HIV/AIDS.
- Strategy 8: Organize and strengthen local and regional offices for a more pertinent and decentralized approach to the STD/HIV/AIDS problem.

The broad scope of the Division's goals, and the close working relationship between the MOH and AIDSCAP mean that the project must often respond to areas beyond its scope of work.

The STD/AIDS Division, as a part of a process of decentralization, is implementing its program through the health regions. This has implications for the success and efficiency of the program, as well as the implementation of the AIDSCAP project. Implementation is slowed predictably through this process. Although ultimately the efforts promise greater sustainability in the short term, annual project goals may be difficult to meet.

The Division also coordinates and supports inter-sectoral efforts such as collaboration with the Ministry of Education, the Ministry of Labor, the Instituto Hondureño de Seguro Social (IHSS), the "Consejo Hondureño de la Empresa Privada" (COHEP, the Honduran Council for Private Enterprise) and various workers' organizations.

For example, with the Ministry of Labor, IHSS, and COHEP, the Ministry of Health is implementing the "Programa de Educación en Enfermedades de Transmisión Sexual y VIH/SIDA para la clase trabajadora en Honduras" (PETSIDA). This new program is just getting started, and adopts a training-of-trainers and peer outreach approach to reaching workers. On the whole, however, as discussed above with reference to STDs, the two institutions—IHSS and the MOH—are quite independent of each other.

The STD/AIDS Division attempts to maintain collaborative relationships with NGOs involved in STDs and HIV/AIDS activities. However, the Division is short staffed, and can provide relatively little support directly to the NGOs. However, a national network that will coordinate all NGOs and PVOs working in prevention and control of HIV/AIDS was recently created by the MOH, but the impact of that network has yet to be felt.

A major achievement in 1994 was the culmination of the first workshop for the nation's religious sector. It enabled the establishment of the first relationships between the STD/AIDS Division and the Catholic and Evangelical churches of the country.

b. The National Surveillance System

Sierra et. al. report the following difficulties with the national surveillance system:

- The first surveillance report forms, developed in 1987 using criteria proposed by the U.S. Centers for Disease Control and Prevention (CDC), are out of date. An excessive amount of time and energy are required to record all of the data requested. They are now being reviewed and new forms are being written.

- Habitual and timely processing of reporting forms is rare. It is common to see no cases reported by a Health Region for a considerable stretch of time, and then suddenly have fifty cases reported.
- There is a lack of uniform criteria to define what information is really needed and indispensable to surveillance.
- There is poor monitoring of private and social security health care sectors.
- The decentralization of the MOH without a transition period did not allow the development of expertise or of specialized teams at a regional level.

2. Condoms

A survey carried out by the STD/AIDS Division in 1994 revealed that 36 percent of all the health centers sampled did not have acceptable quantities of condoms on hand. In other sites, including brothels, military units, and motels, the count of condoms was worse. Condoms are distributed free at health centers. The policy to give condoms only to CSWs has changed and they are now available to all who request them. Sierra et. al. report that the MOH warehouse contains approximately six million condoms.

Condom logistics figures tell very little about use, and there is anecdotal information that condoms are poorly used. Sex workers in Comayagua report using two condoms at the same time with some clients. Most CSWs polled in the recent KAP study report not using condoms with regular partners.

3. International Donors

International cooperative institutions represent the main source of technical and financial support for AIDS prevention and control programs conducted by Honduran government institutions, civic organizations, NGOs, and PVOs. USAID has provided the condoms considered to be the main intervention tool for STD/HIV prevention. In addition, it has played a vital role in providing materials and equipment for information, education, and communication.

Other donor support includes:

UNICEF: Manages an AIDS research and control project in five "barrios" (neighborhoods) of cities with the highest incidence of AIDS. US\$ 250,000, 1993-1995.

World Bank: \$2.1 million for a three-year project aimed at strengthening the MOH's operational capabilities in prevention and control of AIDS. US\$ 2.1 million, 1993-1996.

The European Union: Developed programs through the German Agency for Cooperation (GTZ) and the "Programa de Prevención VIH/SIDA/ETS" (PROPRE), which started operations this year and works closely with the MOH STD/AIDS Division.

4. Non-Governmental Organizations

NGOs currently involved in HIV prevention activities include:

- "Fraternidad Sampedrana de la lucha contra el SIDA" (FRATERNIDAD the San Pedro Sula Brotherhood in the Fight Against AIDS) (AIDSCAP supported)
- "Centro de Orientación y Capacitación en SIDA" (COCSIDA Center for Orientation and Training in AIDS, La Ceiba)
- "Organización de Desarrollo Comunitario" (ODECO Organization for Community Development, La Ceiba) (AIDSCAP supported)
- "Centro de Estudio para el Desarrollo y Participación Social" (CEDEPS Center for Studies on Development and Social Mobilization, Comayagua)
- "Centro de Promoción de Salud Familiar" (Center for the Promotion of Family Health, La Ceiba)
- "Asociación de Instituciones Evangelicas de Honduras" (Association of Honduran Evangelical Institutions, San Pedro Sula)
- "Fundación Amor y Vida" (Love and Life Foundation, San Pedro Sula)
- "Centro Integral para la Atención Familiar" (Integrated Center for Family Attention, San Pedro Sula)
- "Hogar Donde Jesús" (The Home of Jesus, San Pedro Sula)
- "Manos Amigas" (Friendly Hands, San Pedro Sula)
- "Asociación Hondureña de Mujeres contra el SIDA" (AHMSCI Women Against AIDS, Tegucigalpa)
- "Comunicación y Vida" (COMVIDA Communication and Life, with the Municipality of San Pedro Sula)

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- Organización Fraternal Negra Hondureña" (OFRANEH Black Hondurans' Fraternal Organization, La Ceiba) (AIDSCAP supported)
- "Comunidad Gay Sampedrana" (CGS San Pedro Sulan Gay Community) (AIDSCAP supported)

The Central American AIDS Action Project (Proyecto Acción Sida Centro América, PASCA) has developed a list of over 30 NGOs involved in HIV/AIDS.

5. The AIDSCAP Project

Background: In September 1991 USAID entered into a five-year cooperative agreement with Family Health International (FHI) to administer this new branch of the AIDS Technical Support Project—the AIDS Control and Prevention Project (AIDSCAP). AIDSCAP is the single largest component of the U.S. government effort to prevent HIV/AIDS internationally. The original cooperative agreement was converted into a contract in 1994. The five-year contract was just extended for an additional year through 1997. The project is working in five Latin American countries: Brazil, Haiti, Honduras, Jamaica, and the Dominican Republic.

Honduras was designated an AIDS "emphasis country" by USAID based on its high rates of seroprevalence and on the potential for high-impact interventions to have an immediate effect. As discussed by the AIDSCAP/Honduras Country Director, Dr. Jorge Higuero Crespo, in his introduction to "AIDS, HIV Infection and Sexually Transmitted Diseases in Honduras":

*The alarming statistics of AIDS prevalence and transmission in Honduras warrants a multi-sectoral and comprehensive response to the epidemic. Prevention and control of HIV/AIDS requires efforts and resources from both the public and private sectors. Honduras now has over ten years of experience in dealing with the AIDS epidemic. With approximately 57% of all reported cases in Central America and one of the highest rates of infection in the continent, there is a critical need to evaluate and analyze the epidemiology of HIV/AIDS/STDs in the country from a multi-disciplinary approach.*⁷

⁷ Sierra, et. al.

3. State of the Epidemic 1996 : Findings From the Evaluation

A. Seroprevalence and Surveillance

Through May 1996, 5,286 cases of AIDS have been reported in Honduras, and an additional 1,014 persons with AIDS-related complex (ARC), and 1,765 asymptomatic HIV positive persons. In the first five months of 1996, 464 cases have been reported. If annualized, this would amount to 1114 cases, the largest number of cases ever reported in Honduras in a single year.

Available data indicate that levels of HIV infection remain high, but do not reflect the explosive increase reported in Nuñez et. al., (See Bibliography, Annex 3). Data from blood donors suggest an HIV prevalence of 0.5-1 percent in the general population, with higher rates in San Pedro Sula. Prevalence among antenatal mothers in Tegucigalpa has increased from 0.3 percent in 1992 to 1.03 percent in 1996. In San Pedro Sula, it is reported to have remained stable at about four percent. However, in both cities, these figures reflect studies in a single large clinic. These studies are conducted on a sample of women who attend the clinic, but the criteria for selecting these women is not clear. In addition, no information is available from the substantial number of pregnant women receiving prenatal care in the IHSS system in San Pedro Sula.

For comparison, the overall HIV prevalence rate for Latin America is estimated to be slightly more than 0.5 percent, and for the Caribbean, 1.4 percent. In order to understand the difficulties interpreting the seroprevalence figures it is necessary to review the data collection process in some depth.

1. The Data Collection Process

Unlinked anonymous surveys of HIV and syphilis seroprevalence have been conducted annually since 1991 in San Pedro Sula among antenatal women and commercial sex workers (CSWs) attending the Dr. Miguel Paz Barahona health center. The most recent sample of 200 CSWs and 400 pregnant women was obtained in November-December of 1995. The unlinked samples are screened in the health center laboratory for syphilis using the VDRL test, and submitted without identifiers to the regional laboratory where they are frozen, stored, and subsequently tested for HIV. Results of the HIV seroprevalence are reported annually. No cases of syphilis were reported among the antenatal mothers. Among CSWs, syphilis seroprevalence was 14 percent in 1992, 3 percent in 1993, and 1 percent in 1995. HIV seroprevalence is presented in Table 1. This sentinel surveillance has been supervised by Dr. Miguel Eduardo Umaña, who left the

program several months ago. This activity was viewed as a five-year project (1991-1996), and there are currently no plans to continue the survey.

Table 1: HIV Seroprevalence at Sentinel Sites, Honduras			
Site	Year	HIV Prevalence (95% CI)	
		Antenatal	CSWs
San Pedro Sula	1991	3.6% (2.0-6.0)	14% (9.2-20.1)
	1992	2.8% (1.4-4.7)	16.3% (14.2-26.4)
	1993	2% (0.9-4.0)	12.5% (7.8-17.1)
	1994	4% (2.4-6.2)	12.1% (8.1-17.2)
	1995	4.1% (2.4-6.4)	20.5% (15.4-26.4)
Tegucigalpa	1992	0.3% (0.06-0.6)	
	1996	1.03% (0.5-1.84)	
Tela	1994	1.4% (0.6-1.96)	

In Tegucigalpa, sentinel surveillance was recently established in the Las Crucitas Health Center. Once it is operational, the UMIETS at Villa Adela in Comayagua will conduct sentinel surveillance among commercial sex workers. In 1992, an unlinked anonymous survey was conducted among 1,292 women attending six health centers. A second study of HIV and syphilis (using the RPR test) seroprevalence was recently completed among 780 pregnant women from Las Crucitas. Syphilis seroprevalence in these antenatal mothers increased from 0.8 percent in 1992 to 1.41 percent in 1996, and HIV seroprevalence increased from 0.3 percent to 1.03 percent.

An antenatal survey scheduled for 1996 at the Tela Hospital, sentinel site for Health Region 6 (La Ceiba) was canceled because there were too few laboratory technicians. The 1994 anonymous survey among 711 pregnant women from Tela demonstrated an HIV seroprevalence of 1.4 percent. Syphilis seroprevalence information is collected from all antenatal testing sites. There has been significant variation in prevalence from year to year, which may be due to an incomplete screening (Table 2).

Table 2: Antenatal Syphilis Screening - Tela Sentinel Site Sanitary Region 6				
Year	Births	No. Tested	% Tested	% Positive
1990	19,761	5,508	28	0.9
1991	18,568	7,678	41	1.2
1992	19,812	9,868	51	9.2
1993	18,805	9,754	52	7.0
1994	22,745	8,633	38	7.5
1995	17,427	9,410	54	3.5

The 1995 survey of commercial sex workers (CSWs) in San Pedro Sula (conducted in November-December) indicates an HIV prevalence of 20.5 percent, a substantial increase from 12.1 percent in 1994. Preliminary data from a study by Dr. Cesar Nuñez of the STD/AIDS Division of the Ministry of Health indicates an HIV prevalence of nine percent among CSWs in Comayagua.

No recent HIV prevalence information is available for men in general, men who have sex with men (MSM), or the Garífuna—the latter two groups being targets of the AIDSCAP project.

Although the surveillance systems in Honduras have until now been among the best in Central America, it appears that the data currently generated by the regions may be misleading, and does not accurately reflect the epidemic. Although surveillance reports reflect extremely low levels of syphilis and gonorrhea, a study of commercial sex workers currently being conducted by Dr. Cesar Nuñez has found information that is quite contradictory. Preliminary results indicate a prevalence of 20 percent for syphilis, 12 percent for gonorrhea, and nine percent for HIV. (These figures were provided by Dr. Mayté Paredes; the complete study was not available for review.) This suggests that neither the regional nor sentinel surveillance system accurately reflects the STD burden in Honduras, and lends support to the suspicion that either current syphilis testing is not reliable, or the appropriate populations are not gaining access to screening programs. Strengthening of sentinel surveillance, as outlined earlier, may be the most efficient mechanism to more reliably assess STD indicators.

Several factors indicate that AIDS case reporting and HIV surveillance do not accurately reflect the status of the HIV epidemic in Honduras. The distribution of reported AIDS cases by year

(Table 3) suggests a reduction in the annual number of cases in 1994 and 1995. However, reports from hospitals in 1996 suggest an increasing burden. There are several reasons for suspecting that current case reporting and surveillance are inaccurate.

Table 3: Distribution of Reported AIDS Cases in Honduras, by Year		
Year	Cum. No. of Cases	% of Total
1989	260	4.9
1990	605	11.4
1991	514	9.7
1992	752	14.2
1993	974	18.4
1994	867	16.4
1995	850	16.1
1996 (5 mos.)	464	8.7

- **Misclassification in the HIV Case Reporting System.** AIDS cases are reported on the ficha accompanying the request for the HIV blood test at the time of first testing. On this form, the patient is classified into one of three categories, according to symptoms present at the time of testing: AIDS (meeting the Caracas case definition), AIDS-related complex (ARC), or an asymptomatic carrier. As there is no subsequent clinical case report, there is no mechanism to update this classification. That is, once a patient is classified as asymptomatic or ARC, this classification remains in the system, even though the patient subsequently develops AIDS. This results in a significant underestimation of AIDS cases. Through May 1996 there have been 1,014 cases reported as ARC and 1,765 reported as asymptomatic carriers. It is not possible to determine how many of these are now actually AIDS cases. However, as testing has become more available, and an increasing number of persons are tested earlier in their course of the HIV disease, the number of ARC and asymptomatic cases is increasing.

Of note, Honduras has employed a reporting system using patient names. San Pedro Sula is considering the use of a code reporting system, in lieu of names for Health Region 3.

The proposed code system presents several disadvantages, in that the code is not unique, and the likelihood of duplicate and inaccurate reports is high. Unless there is a compelling reason to move to this code system, it does not appear warranted.

- **Under Reporting of Identified HIV Positive Persons.** Case reports are generated only for patients tested in MOH or IHSS laboratories. Other testing sources are not likely reported. For example, in addition to blood donors, the Honduras Red Cross provides fee-for-service testing for patients with a doctor's order, and identifies 230-280 persons positive for HIV each year. The number (though not names) of HIV positive blood donors are reported to the MOH, but the Red Cross does not report these other patients who test HIV positive, assuming that they would be reported by the doctor ordering the test. There does not appear to be a mechanism to do so, and such reporting happens infrequently.
- **Lack of testing.** Although HIV testing is widely available, there appear to be many reasons for persons to avoid voluntary testing: little early treatment is available, HIV positive persons face substantial discrimination in employment and in the community, and support systems for HIV infected persons are not well developed. The high HIV prevalence among persons tested voluntarily (Table 4) suggests that only persons with symptoms or who are at highest risk seek testing.

Table 4: Voluntary HIV Test Results, General Population, Honduras			
Year	Persons Tested	No. HIV+	% HIV+
1989	4,987	496	10
1990	8,477	1,003	12
1991	10,841	2,406	22
1992	13,905	1,251	18
1993	14,047	2,153	15
1994	12,877	2,379	18
1995	12,853	1,360	10

2. Monitoring the Status of the Epidemic

Given these circumstances, it is difficult to determine the actual status of the epidemic. Blood donor screening can be used to give some general indication of HIV prevalence in the general population. The reduction in seroprevalence after the introduction of donor referral

questionnaires in 1990 suggests that persons at high risk for HIV are excluded from this population. Despite this fact, HIV prevalence has remained consistently high in blood donors recruited both by hospitals and by the Red Cross. The highest HIV prevalence among volunteer blood donors has been observed in San Pedro Sula, hovering around one percent (Table 5).

Table 5: HIV Prevalence (%) Among Blood Donors, Honduras			
Year	Hospital Donors	Red Cross Tegucigalpa	Red Cross San Pedro Sula
1990	0.34	0.60	1.68
1991	0.40	0.20	1.20
1992	0.60	0.25	0.80
1993	0.65	0.47	0.98
1994	0.75	0.31	0.73
1995	0.56	0.27	0.56

The inferences that can be drawn from available data suggest that HIV infection continues to be well established in the Honduran population. Although there is no evidence of an explosive increase, there is also none to suggest that prevalence is subsiding. Importantly, there are few data on persons at highest risk, and virtually none for MSM.

Additionally, information on risk factors for transmission may not be reliable. This information is collected at the time blood is drawn, and additional information obtained when persons are counseled at the time they receive positive test results is not reflected in the case reports. Studies in other countries have shown that risk factors other than heterosexual transmission are often identified during subsequent interviews.

Several options exist for monitoring the progress of the epidemic:

- **Targeted seroprevalence surveys in specific populations may be helpful in guiding prevention efforts.** Specifically, little reliable information is available among MSM and the Garífuna population to determine the extent of the epidemic in these high priority groups.
- **Case Investigations.** It is not practical to reinvestigate the persons who have been reported as asymptomatic or ARC to determine their status. Although this could better

define the actual number of cases, it would be difficult to justify the necessary expenditure of effort and resources without a specific justification, as it would provide little information on where the HIV epidemic is moving in Honduras. However, a more careful interview of recently diagnosed cases by trained counselors may help to provide more accurate information about how and where HIV is spreading. Such interviews could develop more detailed information on sexual histories, possible contacts, travel, etc., and potentially guide subsequent prevention efforts. Many of these interviews already take place during post-test counseling, but the information is not collected in a systematic fashion.

- **Clinical Case Reporting.** It would be prudent to initiate a system of clinical case reporting, whereby hospitals and physicians would report persons who present with symptomatic AIDS, regardless of when or where they were first tested for HIV. This would help to develop more accurate information on AIDS incidence in the future. As Honduras uses a system of name reporting, duplicate case reports could be avoided by using an adequate data system. It is likely that a combination of these methods will be necessary to provide sufficient information.
- **STD Surveillance.** MOH reports continue to reflect declining levels of syphilis and gonorrhea. Sentinel surveillance among antenatal mothers in San Pedro Sula and Tegucigalpa reflects low levels of syphilis in antenatal mothers, and a substantial decline among CSWs in San Pedro Sula. (No CSW data are available from Tegucigalpa.) The reported levels (1%) are so low as to be unbelievable, in view of the observed HIV prevalence. Syphilis seroprevalence was 20 percent among CSWs in Dr. Nuñez's study in Comayagua, suggesting that the sentinel surveillance data is unreliable. General antenatal screening for syphilis, though a national standard, is inconsistent; it appears to reach 35-50 percent of pregnant women. Reagent shortages and difficulty with specimen transport and preservation are frequently cited as the reasons for the low rates of screening.
- **STD Treatment.** Country guidelines for syndromic STD management have been developed, and training for 32 health care workers from the newly developed STD clinics (UMIETS) in the four project areas was conducted during the last week of August 1996. Enhanced systems for STD diagnosis and treatment using a syndromic approach are now being implemented. During this evaluation Dr. Francoise Crabbé of the Institute of Tropical Medicine, an AIDSCAP subcontractor, and AIDSCAP staff initiated the first training workshop for syndromic management of STDs. The MOH has arranged for supplies of the necessary drugs through the World Bank, but these are not yet available in the clinics. AIDSCAP has initiated a study to determine antibiotic susceptibilities of STD pathogens in Honduras, but specimen collection has been slower than expected and no results are available.

Syndromic management will be piloted in the four UMIETS. It is planned that these will then serve as training resources for persons in area health centers. Region 3 will begin training of personnel in peripheral clinics in September 1996.

The four UMIETS have been refurbished and laboratory capabilities have been upgraded. CSWs are the primary clients of these clinics, many of whom are currently receiving STD care at health centers under the program of "control." It appears that most of these women are bordello-based, while a large number of street walkers are not being effectively reached. Efforts have not yet begun to attract other CSWs not receiving care to the clinics, nor other persons in need of STD treatment.

Most of these efforts in enhanced STD therapy appear to have been focused on CSWs, through the development of UMIETS. An effective mechanism has not yet been developed to increase the coverage among CSWs not currently involved in control. For example, a group of women come into Comayagua each weekend, offering sex services to servicemen from the Palmerola base. These women do not consider themselves to be CSWs, and there has been little success in reaching them for services. Perhaps specific NGO activities can help to access groups such as these.

More importantly, there has been little progress made toward improving STD services for their clients, for men who have sex with men (MSM), nor for the Garífuna population. The UMIETS were developed primarily in response to CSWs complaints about discrimination in Ministry clinics. The UMIETS permit the delivery of integrated services such as women's health and health care for their children. However, this addresses a relatively small proportion of the population at high risk for STDs. On the one hand, many women and men with multiple partners do not identify as CSWs. On the other hand, although a small number of male CSWs receive services at the UMIETS in Tegucigalpa and San Pedro Sula, there appear to be few resources available for MSM or for men in general, and little effort to bring them into care. Men represent two-thirds of the AIDS cases in Honduras, but women comprise the majority of those receiving care for STD symptoms at the UMIETS.

Health Region 3 is planning such an extension of improved STD services, training all relevant staff throughout the region. Supply of drugs, however, is likely to be a problem.

Greater involvement and coordination with IHSS in San Pedro Sula is also essential. IHSS provides health care for a significant proportion of working men through their clinics and hospital in Health Region 3. Within IHSS itself, it appears that few resources have been made available to suggest that either enhanced STD care or HIV prevention in IHSS Region Norte (San Pedro Sula, Progreso, and surrounding areas) represent a priority. IHSS is responsible for a large proportion of the population in this region which represents an area that has reported approximately half of all AIDS cases in Honduras, and where the highest seroprevalence rates in

the country have been documented. Although a doctor has been assigned to an STD clinic planned at the IHSS hospital in San Pedro Sula, the clinic has been neither equipped nor supplied, and the medications necessary for syndromic treatment are not available. Despite a large number of hospitalized AIDS cases and deaths, no infectious disease specialist is available at the hospital.

Data from the NGO baseline surveys and the recent National Epidemiology and Family Health male module may be useful to gain insight into where men currently receive health services, and to design mechanisms to increase their access for STD care. It is possible that the scope of the UMIETS could be expanded to deliver STD care for more men as well as women. However, it will also likely be necessary to include the entire Ministry health system, private physicians, and pharmacies in efforts to enhance STD treatment for men. Strategies for NGOs working with MSM and Garífuna must also include specific promotion of recognition of STD symptoms and the need to seek treatment.

The social security health system (IHSS), an employer supported health care system, has not been involved in the process of introducing syndromic treatment, uses a different set of treatment guidelines, and does not have access to the drugs necessary for syndromic treatment. This appears to be a particular problem in San Pedro Sula, where IHSS is the care provider to a significant proportion of the population susceptible to STD and HIV. The IHSS hospital in San Pedro Sula received AIDSCAP support for strengthening of its laboratory, but the planned STD clinic has not yet been developed. As an initial step, materials to refurbish and equip the STD clinic at the IHSS Hospital in San Pedro Sula would develop an important resource to expand STD services.

There are a limited number of staff trained in syndromic therapy in the UMIETS and in the Health Regions. Since adequate training requires one week, it would appear that either the training or clinical services will suffer if currently trained personnel are to train a sufficient number of persons in area health centers. An adequate supply of training materials, in particular a pocket guide with flow diagrams for syndromic management, must be available to health providers in all health centers.

Support for two additional studies may also help ensure that syndromic management of STDs succeeds in Honduras. First, skepticism remains about the adoption and sustainability of syndromic treatment. Ministry personnel ask for evidence that it has been successful elsewhere in Latin America. A study to validate the effectiveness (compared to the etiologic or clinical approaches) would generate benefits for Honduras and elsewhere. Second, a cost-effectiveness analysis would also help to develop persuasive evidence that the syndromic approach is in fact able to achieve positive health outcomes and a reduction in disease at an affordable cost.

B. The Response

1. MOH Response

a. STD/HIV Division

Although a review of the MOH STD/HIV Division was not within the scope of work of this evaluation, coordination between AIDSCAP and the Division was. Additionally, there are several relevant observations to be made about the state of the national program.

The national AIDS control program is managed by the STD/AIDS Division of the Ministry of Health. The Division is supervised by Vice-Minister of Health, Dra. Virginia Espinoza and Director-General, Dr. Enrique Zelaya, epidemiologist and former head of the program. The Division coordinates with USAID and AIDSCAP through a Central Coordinating Committee (CCC) consisting of: Dra. Mayté Paredes, Director of the Division; Dr. Jorge Higuero Crespo, AIDSCAP Country Director; Dr. David Losk, USAID Health Officer; and Dr. Jorge Fernandez, former Director of the Division and Coordinator of International Assistance in HIV/AIDS. The CCC reports to the Ministry, USAID/Honduras, the National AIDS Commission (COMSIDA), and the Interagency Coordinating Committee (ICC).

Difficulties exist with this organigram, however. First, COMSIDA rarely meets. The ICC does meet occasionally, but includes many programs on its agenda. The CCC serves to coordinate USAID inputs, but spends most of its time dealing with technical issues. Because both COMSIDA and ICC are either dormant or preoccupied with other issues, there is a need for a separate mechanism to guarantee political access for AIDSCAP.

The STD/HIV/AIDS Division operates within an evolving Ministry framework of decentralization. Regions 2, 3, 6, and the Metropolitan Region are the implementors of most of the Divisions' programs. Coordination with Regional authorities is being maintained at present, but could be improved, especially on the North Coast. The new Medium Term Plan might consider mechanisms for enhancing coordination.

Although the Division had been quite successful in managing STD/HIV prevention activities, it has suffered several recent blows. First its budget has been cut several times by the Ministry, and second it has lost three STD/HIV public health specialists within the past year. At the beginning of 1996, the Division had four professionals with substantial experience working in HIV/AIDS. Currently, one has left, and two are out of the country for training. Hopefully they will return after training. At this moment, there are no staff assigned to surveillance. In the area of education, two general practitioners with little health education experience, one nurse, a journalist, and a social worker have been assigned to work on HIV/AIDS education materials. In the Office of Atención and Reducción de Impacto, three general practitioners with little

experience have been assigned. Three staff work in administration, and nine non-technical support staff support the activities of the Division. In addition, several regional staff have left the Ministry as well.

USAID should permit AIDSCAP to provide the Ministry a full-time staff person to assist in the activities of the Division. The ideal candidate would be an HIV prevention specialist with significant management and administrative expertise. The Division also needs expertise in the areas of behavior change communication and behavioral research. The scope of work of this staff person should be limited to activities specified within the AIDSCAP delivery order.

The Division had been operating under a Medium Term Plan developed jointly with PAHO/GPA/UNAIDS. That plan will end this fall. As a basis for evaluating AIDSCAP, planning the extension of AIDSCAP, coordinating international donors, focusing on NGOs, and determining the future direction of USAID support in this area of Honduras, it is essential to develop a new Medium Term Plan, or a similar document. USAID, through AIDSCAP, should support the development of a new Medium Term Plan during the last quarter of CY1996. This will involve convening international donors and agencies, such as other Ministries and sectors, (i.e., Education and IHSS); and inviting expert participation where needed (strategic planning, surveillance, evaluation, STDs, public health communication, and other intervention areas such as testing and counseling).

b. The Division of Health Education

Although an assessment of the health education program of the Division was not part of the scope of work of this evaluation, this program is relevant for AIDSCAP efforts.

In 1994 the STD/AIDS Division designed a three-year Information, Education, and Communication (IEC) plan of action to guide NGOs and the Health Regions. The plan's aim is to "saturate society with educational information" in order to "modify specific risk behaviors in the population." Another stated objective is to "obtain a wide and sustained social mobilization and to sensitize society about the social cost of this deadly disease."

Media proposed included electronic, face-to-face, and print. Young adults, 15 to 25, are the target group. Secondary audiences are parents, teachers, religious leaders, politicians, workers' leaders, and businessmen.

As part of promotion and awareness activities, the STD/AIDS Division has contracted private publicity firms to design messages directed to the general population. Some examples of these are: "Vida o SIDA. Usted decida" (Life or AIDS, You decide); "El SIDA: dos caras de la misma moneda" (AIDS: two faces of the same coin); "En los tiempos del SIDA no hay victimas ni culpables" (In the era of AIDS there are neither victims nor the guilty); "El SIDA puede hacer

del juego sexual, un juego mortal" (AIDS can turn a sex game into a deadly game); "Fidelidad sexual conyugal" (sexual fidelity between partners); "Ante el SIDA, el condón es buena protección" (Against AIDS, Condoms are good protection); and "No dejes que el SIDA destruya tu vida" (Don't let AIDS destroy your life).

Messages are displayed on posters in public places, some have been put on bumper stickers, and others have been broadcast on radio and TV. The STD/AIDS Division has organized public campaigns to distribute free condoms in main urban centers of the country.

It is unclear what effect, if any, these efforts have had. In terms of communication strategies adopted by the Division, only saturation appears to have been satisfied. There is little call for action in these messages, or ties to other elements of the campaign, such as a social mobilization effort. In general, awareness of HIV, its mode of transmission, the need to reduce the number of sexual partners and the need to use condoms is high in Honduras. These messages do not appear to offer anything new, nor do they focus on new strategies or behaviors. Their presence, of course, keeps HIV/AIDS in the public eye, but miss valuable opportunities to create conditions for behavior change. For example, with the introduction of a syndromic approach, radio and TV could be used in a synchronized manner to promote this new management of STDs and encourage the public to use health clinics, rather than self medicate, which is the norm.

The approach of "saturating society with educational messages" is probably misguided. This approach is often characterized as an "information-based" approach to behavior change. Information-based approaches are rarely successful by themselves, especially when knowledge levels are high, as in Honduras. Given the results of the surveys conducted during AIDSCAP/Honduras' first year (and from experience elsewhere), reasons for performing unsafe sex rarely include lack of knowledge of HIV, means of transmission, or ignorance of the role of condoms.

Another example of this information-based approach are the materials developed for the PETSIDA Project. These materials, designed for use with factory workers, were developed by physicians and summarize available epidemiological and virological knowledge about the epidemic. They are both too long and too complicated for their intended audience, especially since this was meant to be a peer-based intervention. Long written sections using scientific language, albeit somewhat simplified, is both inappropriate for the reading level of the intended audience and a poor behavior change strategy. Their use, by the way, was simply didactic: workers were given long lectures and readings from the text.

The hard work of systematically identifying barriers to condom use, other HIV/STD prevention interventions and their barriers, and the development of strategies to overcome those barriers, is just beginning. This approach, part of a behavior change communication strategy, is what AIDSCAP and the Ministry need to focus on.

A second concern is that health education efforts are focused on relatively narrow areas, and on tangible products such as the development of posters and print materials rather than on integrated programs that use these materials in small-group settings or in counseling. This can be seen in the logframes attached to the IA subagreements which, like the AIDSCAP logframe, lists outputs of fliers and posters rather than indicators of behavior change. Additionally, areas such as small-group counseling, skill training, peer outreach, counseling and testing, and community mobilization—which are known to be effective—are either underdeveloped or not stated in the logframe.

In order to improve the quality of this component, AIDSCAP and the Division have implemented a technical committee to review the development of communication plans, pre-tests of messages and materials and their final development. This committee includes the relatively isolated Health Education Division of the Ministry, and is a good first step in utilizing a resource that has been well supported by USAID over the years, but which is now underutilized.

Technical assistance is required in the area of public health communication to provide training to Ministry staff in health communication; to provide assistance in actual design, development and evaluation of materials and communication strategies; and to provide guidelines for development of diverse interventions such as small-group counseling.

2. AIDSCAP Response

The AIDSCAP Honduras Country Office has had an impressive first year. The delivery order that first funded the project is dated February 8, 1995. Country program activities began May 22, 1995. Within three months of the start of the project ten subcontracts with implementing agencies (IA) including seven NGOs were executed. This is an all time record in the history of the worldwide AIDSCAP project, representing new accelerated approval processes, close collaboration with USAID and the Ministry of Health, and the targeting and preselection of IAs developed in the buy-in by USAID/Honduras. The project recruited an excellent local staff including:

Table 6: AIDSCAP/Honduras Staff	
Dr. Jorge Higuero Crespo, MD	Country Director
Dr. Emma Margarita Iriarte, MD, MPH	Program Officer
Dr. Leda Bolaños	Evaluation Officer
Lic. Maria Elena Ordoñez	Communication
Lic. Maria Concepción Cáceres	Finance Officer

Dr. Higuero Crespo is a distinguished public health specialist in Honduras, having served as Director General of the Ministry of Health and in other important offices. Dr. Iriarte is a young and capable physician with a specialty in epidemiology and public health, having just completed her MPH at Tulane. Dr. Leda Bolaños is a physician and senior academic who taught evaluation and survey research at the Honduran National Autonomous University. Although Lic. Ordonez has no formal training in health communication, she worked closely with the Health Education Division in Health Region 2 before joining the project; is an accomplished health educator; and has done a considerable job in improving the quality of health education materials in the project. Lic. Cáceres is the accountant who helped train the IAs and who discovered fiscal irregularities in two of the subcontracts. Furthermore, the project staff have been exceptionally dedicated, working overtime and on weekends and holidays to accomplish project goals. The project staff works together very well.

The project maintains a close working relationship with the Ministry of Health and with donors. In fact, in interviews with other donors and implementing agencies such as the MOH, the UN system, PAHO, and JICA, AIDSCAP was universally praised for their close working relationship and support. This is an extremely unusual finding.

Major accomplishments of the first year of the project include:

- Implemented subagreements with the Junta Nacional de Bienestar Familiar (JNBS), MOH, and IHSS
- Completed seven initial KAP surveys and focus group interviews (analysis not complete)
- Trained IAs in accounting and reporting requirements
- Trained IAs in evaluation methodologies
- Provided computers, training, and other equipment to the IAs to enhance their capabilities
- Assisted the STD/HIV Division in the areas of design, planning, human sexuality evaluation, behavioral research, and the development and testing of BCC materials
- Assisted the STD/HIV Division to develop a Manual for Syndromic Treatment of STDs
- Assisted the STD/HIV Division to develop a Manual of STD Management among commercial sex workers
- Assisted the STD/HIV Division and Plan International to conduct qualitative and quantitative research on adolescent sexuality in preparation for the development of new curricula for schools
- Worked closely with journalists from Health Regions Metro, 2, 3, and 6
- Established a Technical Committee within the Ministry to coordinate the development of communication programs
- Supported IA/IHSS workshops for plant managers and union leaders to develop the legal framework for a proposed AIDS law, and to reduce workplace dismissals of seropositives
- Supported repairs, remodeling, and equipment for the four UMIETs
- Supported COCSIDA, one of the IAs, in their efforts to reduce police abuse of CSWs.

These accomplishments are all the more remarkable given the short duration of the project. Although as measured by the project logframe, some of these accomplishments fall short of stated goals, the evaluation team believes that progress to date has been substantial, and that the project logframe indicators need to be revisited. This is due, in part, to the artificial two-year life span of the Honduras component of the global AIDSCAP project, as will be discussed below.

a. Indicators

A major finding of this evaluation was the need to develop a single set of indicators for AIDSCAP and for the Mission. The existence of diverse indicators identified in the global AIDSCAP project logframe, the USAID/Honduras Health Sector II Extension planning exercise (1995), a fax from Dr. Robert Martinez to Dr. Stan Terrell 12/5/95, and the Results Review and Resource Request (R4) developed in March 1996, complicates evaluation plans and the need to satisfy USAID reporting requirements.

The latter two documents supersede previous efforts for reporting requirements, while the logframe associated with the delivery order of the global AIDSCAP project is actually being used by AIDSCAP for project planning.

Two documents are the most current and relevant. The R4 is the required reporting document for the Mission. This document lists the following indicators:

- Strategic Objective No. 3—Improved Family Health
- Intermediate Result No. 3.3—Increased Use of STD/AIDS Prevention Practices
- Indicator 3.3a—Increased Total Number of Condoms Distributed (sold and handed out) (This indicator sets a target of 7,200,000 condoms for 1996. This indicator will be dropped in 1997, to be replaced by 3.3b, 3.3c, and 3.3d, which are below, and are in effect now.)

It needs to be pointed out that indicator 3.3a is a global indicator for all health assistance, and that distribution is only partially carried out by AIDSCAP. In fact, AIDSCAP distributes about 50,000 condoms per month through its NGOs. AIDSCAP has also been asked to assist the Ministry to improve condom logistics, but since the bulk of condoms are distributed through the family planning program this indicator is hardly appropriate for measuring condom coverage of the AIDSCAP Project or the Ministry.

The new indicators are:

3.3b Increased Rate of Reported Condom Use in the Most Recent Sexual Intercourse of Risk in Target Population. This indicator is meant to be measured by the KAP surveys conducted by the AIDSCAP IAs among their respective target populations.

The KAP surveys just conducted have serious difficulties for measuring achievement, as will be discussed below. It only needs to be mentioned here that sampling is strongly biased and populations poorly defined, making interpretation of results extremely difficult. In addition, defining at-risk intercourse is difficult and confusing, especially for women who have a single partner, or serial partners. It is likely that year-to-year changes will be more likely due to sampling and response bias, rather than to real changes in behavior of the target population. Additionally, the recently-conducted surveys occupied much of the time of the first year of the project, and for the purpose of indicators, need to be collected annually. This would place too much emphasis on the limited resources and research skills of the IAs, and would not be an effective expenditure of project resources.

This indicator was derived from WHO/GPA developed indicators. Actual achievement, taken from the KAP surveys and planned goals, are reported in the R4, and many of the former are extremely high. For example, CSWs report a condom use rate of 87 percent, while their “clients” (actually, just men selected from the general population) report a use of 65 percent. It is unlikely that 87 percent of sex workers in SPS used a condom in their last act of intercourse. In fact, the most likely outcome is that in a subsequent survey the number would drop. Sixty-nine percent of Garífuna men reported using a condom, while only 28 percent of women did. Multiple interpretations can be given for these results.

This indicator might be maintained, however, if data from the recently completed male module of the EFHS can provide reliable information about condom use in the project Health Regions. In order to assure that this is the case, USAID needs to determine if the sampling can be reproduced and if the sample size is large enough in the project areas. Since individual estimates do not need to be made for each city, region, or site, the sample should be large enough to provide a reliable estimate of condom use. This male module could be repeated in 1998 to report on progress.

If this recommendation is accepted, several consequences follow: 1) AIDSCAP and the NGOs are relieved of this responsibility of measuring condom use in surveys—they can report project process monitoring data; 2) the indicator implies a shift to general population targets, probably required to achieve seroprevalence targets; 3) the 1998 survey could include items about exposure to the program interventions, so that the data collection exercise could be potentially used as a summary evaluation exercise.

3.3c Decreased Rate of Reported Non-Regular Sex Partners in Target Population

As above, this indicator was meant to be collected through the IA KAP surveys. Definition of “non-regular” partner is difficult. This indicator is inappropriate, of course, for sex workers. For the Garífuna, there is anecdotal information about the routine maintenance of multiple long-term partners.

This indicator is problematic as well in terms of both potential impact on transmission (what does the reduction of four partners to three mean in the Honduran context) and its link to project inputs. This indicator can be reported from the male module of the EFHS, and data on this indicator could be collected in the future. However, as a reportable indicator we recommend that it be dropped.

3.3d Increased Percentage of Individuals Presenting with STD in Health Facilities Assessed and Treated Appropriately per National Standards.

This is a measure of health facility performance but it remains to be seen how this is measured. Does this indicator refer to the proportion of cases in a region receiving syndromic care? The proportion of health facilities offering care? Does it refer to the proportion of cases cured, independent of method? In short, what is the denominator? This indicator should be changed and expressed as the proportion of health facilities correctly assessing and treating STD patients with the syndromic approach.

3.E Maintained HIV seroprevalence rate in CSWs and women attending a prenatal clinic.

Difficulties with this indicator are discussed in the surveillance section above. This data is normally collected during the last two months of the year from a single sentinel site in SPS. However, this data should continue to be collected.

These four indicators conclude the indicators needed by USAID. However, as currently constructed these indicators have relatively little to do with actual program performance, or the detailed description of approaches included in the delivery order.

The fax sent by the AIDSCAP Evaluation Office Director, Dr. Robert Martinez includes the indicators 3b, 3c, 3d discussed above, although they are numbered quite differently (5.1a, 4.1a, and 6.1, respectively). It includes additional indicators as well, such as, "Increase in the rate of number of reported episodes of urethritis in men aged 15-49 in the last 12 months in AIDSCAP targeted populations" to be measured in annual surveys. These indicators were never implemented.

The AIDSCAP project is actually using another set of indicators to measure progress which are part of the global AIDSCAP logframe and included in the original proposal for the Honduras program. Naturally, the R4 indicators supersede these indicators, but the global AIDSCAP project can legitimately request collection of data for the logframe mandated by USAID/Washington. In all, 34 indicators are mentioned.

The expected end of project date for the Honduras activity also coincided with the EOP of the global AIDSCAP project, giving the project a two-year life (1995-1997). It is unrealistic to assume that a behavior change project could achieve an impact in this time frame. However, since some of these "indicators" are currently being used for program planning and they may be useful for EOP 1999, they will be reviewed:

The logframe states as its objectives:

Prevalence of HIV maintained at 0.3% or less in Tegucigalpa, 1.5% or less in Region 2, 3.6% or less in Region 3; and 1.4% or less in Region 6. [Country Program Indicator or CPI 10⁸]. This is an unrealistic set of expectations. Current rates are higher in almost all regions, and it is unclear if these statistics, which reflect general population effects, will be impacted by program activities. Since expectations are that the percentage of antenatal women who are HIV+ will continue to increase each year, an extremely ambitious target would be to maintain current levels. However, as mentioned above, SPS figures of four percent seem suspect. As with all the indicators here, in setting new targets, USAID and AIDSCAP should take into account real targets. How many, and what population of women need to be reached to achieve this goal?

Prevalence of syphilis is maintained at 15% or less. [CPI 8]. It is difficult to determine the true rate for syphilis. Once the sentinel surveillance system is in place and functioning, this indicator should be changed to: a) reflect only target populations for the project; and b) represent a stable population for measurement.

The prevalence of HIV is maintained at 5.5% or less in the metropolitan area of Tegucigalpa; 19.8% or less in SPS in sex workers. This indicator reflects a hard-to-define population, i.e., what kind of sex worker? Also, rates of 15.5% and 19.8% provide false precision. We recommend that when new indicators are reformulated, this indicator be dropped in favor of service and treatment indicators.

The logframe then refers to goals. These indicators are CPI 1, 3, 4, 5, and 6. (CPI 5 is equivalent to R4 3.3b, the other four are all different).

CPI 4 Reduction in one or more sexual partners in the last 12 months. It is unclear what impact this might have on the epidemic. How does moving from four partners to three affect impact? It is much more likely that any change in this number is due to chance or personal issues in the lives of the partners than to project inputs.

⁸The CPIs were originally developed by WHO/GPA for use around the world. USAID and WHO/GPA committed to using these indicators. WHO/GPA, however, ended two years ago.

CPI 1 Increase in the proportion of interviewed able to identify at least two HIV prevention strategies. This figure is already quite high in the target populations in the project. Targets are not set.

CPI 3 Increase in the population (15-49) that can acquire a condom. This indicator depends simply on the definition of acquire. One is curious about the age range as well. Targets are not set.

CPI 6 80% of the target population with an STD receive appropriate treatment. This indicator includes a target population, but the actual intent is to collect information not mentioned. The logframe actually mentions narrative reports and focus groups, which is inappropriate. Measuring this indicator will require a careful definition of the target population. In many cases the target population is broadly defined, such as male clients of sex workers. This indicator should be reconstructed to:

- Reflect the proportion of health services correctly providing syndromic therapy.
- Reflect the proportion of a well-defined target population such as the population of workers in several workplaces involved in the project, and the population of registered CSWs involved in project activities.

These are behavioral indicators that were to be derived from the KAP surveys conducted for the project. As discussed here, these surveys, with the possible exception of the IHSS survey, cannot be used to measure these indicators. Instead, a post-only design is proposed below. The indicators should be changed to reflect not pre- and post differences, but post-only exposed and unexposed groups. In translation to a results framework and in addition to numerical outcomes, qualitative targets (i.e., historical and anecdotal information) may be used to assess the more difficult to measure impact of the projects on the target population. Although not providing a rigorous and precise measure of outcomes, it will permit a broader evaluation of program effect.

CPI 7 50% of the target population with STD receives prevention education and counseling about notifying partners. This indicator requires that 50 percent of the target population with STD receive counseling. Again, as in CPI 6, this indicator should reflect the proportion of clinics providing adequate counseling, and the proportion of well-defined target cases. It is unclear why this figure is not 100 percent.

The logframe provides the following additional indicators: (numbers refers to logframe numbering system)

1.3 80% of the target population is conscious of or has access to improved STD services. As above, this indicator will be difficult to measure. Its significance is unclear. "Conscious of" or "has access to" are quite different. This might be changed to:

1.3 Target populations in the workplace, sex workers, and MSM have access to improved STD services (access defined as a facility within five km or one-half hour by bus or other transport, or a facility designed expressly for sex workers and MSM in the same town or within one-half hour by bus transport). Since providing these services is an explicit part of the STD program, this indicator might conveniently be dropped.

1.4 At least 25,000 condoms a month be distributed from each of the four clinics that participate in project activities at the end of the 2nd year. Since condoms are being distributed from many sites, this indicator should be part of a set of indicators concerning condom logistics, distribution, and use that needs to be formulated (Section 3, below). The project is currently distributing 50,000 condoms a month from more than the four UMIET sites. This indicator is due to be dropped in 1997. However the replacement indicators require annual KAP studies. We strongly recommend that this be reconsidered, since the NGOs do not have the capacity to conduct these studies. See the discussion of the KAP surveys for further details.

1.5 One training session a month conducted by clinic staff at the start of the second year. This indicator along with 2.1, 2.2, 2.3, and 2.4 begins a series of health communication indicators that are: a) "outcomes" and logistic in nature; and b) not concerned with impact. If the post-test-only evaluation plan is adopted, a broader range of measures of health communication impact should be adopted. These indicators would measure exposure to the program, recognition of content, knowledge of content, and reports of behavior change. This indicator requires that at the start of the second year of the project, these training sessions are being conducted. This is currently not the case, and this indicator has not yet been achieved.

1.6 nota bene 1.6 is skipped in the logframe.

1.7 At least 25% of clients diagnosed with STD are referred. The referral system is not yet operational, and a quantitative target for this indicator reflects epidemiological variables that are not controllable. This indicator should be reconstructed, if required, to target the population using STD services correctly and who are appropriately referred.

1.8 Establishment of a National STD Committee. No National STD committee has been organized, nor is one recommended by this report. Instead, STDs are already incorporated in the MOH Division of STD/HIV.

Indicators for Section 2 of the logframe include the numerical and logistical outputs of this health education component. These outputs are incorrectly identified as indicators. In reengineered language, these are benchmarks masquerading as results. Results here should be reformulated as behaviors which can be measured at EOP.

Indicators for Section 3 represent condom logistics; Indicator 3.4 represents condom use. With the exception of 3.4 (which has not been measured) and 3.5, the project appears to have already satisfied these indicators.

Indicators for Section 4 refer to assistance to the implementing agencies, and have all been met. It is unnecessary to have proportional indicators here, i.e. 80 percent of IAs implement HIV prevention programs, since all are involved. It is unclear if these set of indicators are required at all.

Indicators for Section 5 involve raising the consciousness of the general population concerning HIV, and involving distribution of the socioeconomic impact study. This study is somewhat dated, however, and appears to have created confusion about the path of the epidemic. It predicts a much higher number of cases than appears to be found. Its widespread distribution should be stopped. These indicators should reflect the relationship AIDSCAP has forged with the press and other media, and policy dialogue.

Summary Recommendation: Although the AIDSCAP-identified logframe indicators may be useful for planning, they are no longer relevant as indicators of project performance for the USAID Mission and are difficult to measure. More appropriate indicators are the ones identified by USAID/Honduras for reporting to USAID/W. For reasons suggested above, the indicators to be adopted by the Mission are:

- 3.E Seroprevalence in CSWs and women attending an antenatal clinic in San Pedro Sula.**
- 3.3b Increased rate of condom use in most recent at-risk intercourse.**
- 3.3d Increased proportion of health facilities assessing and treating STDs with syndromic approach.**

The new approach and results framework will require some reprogramming of project activities. Although wholesale changes in NGOs, target groups, or strategies are not recommended in the next year of the project, the new indicators and results orientation and expectations for 1998 impact require that project activities give emphasis to:

- Syndromic management of STDs and improving health seeking behavior for STDs in the Project's area of influence: Health Regions Metro, 2, 3, and 6
- Improved surveillance in the four Regions
- Behavior Change Communication, both in assisting the MOH at the national level, in the four project Regions, and in the project NGOs.

The project needs to promote syndromic therapy in as many clinics and facilities as possible in the four Regions over the short term. The project needs to guarantee that surveillance activities in the sentinel sites, especially the two sites in San Pedro Sula, are correctly conducted this year

and throughout the life of the project. Finally the project needs to guarantee that effective behavior change communication is used by the Ministry and NGOs in the project area, so that as many people as possible adopt appropriate condom use and health seeking practices for STDs. These are currently substantive areas where USAID has a comparative advantage in comparison to other donors, and which have been identified by the MOH and AIDSCAP as critical areas.

Lost in the multiple lists of indicators is the relationship of project activities to proposed activities in the delivery order. Audiences targeted in the delivery order—sex workers, male clients of sex workers, Garifuna, workers in maquilas (foreign owned factories which have concessionary arrangements with the government to escape certain regulations) and factories, and men who have sex with men—are a special concern. Many project activities affect other audiences, such as support to the Ministry of Health to reach general population audiences, or support to Plan International to help develop curricula for in-school youth. Although project activities need to stay focused in the short term, it needs to be noted that the epidemic has moved beyond the special target audiences. The project needs to be able to support NGOs and the Ministry in new areas and to have the flexibility to move beyond these targets. This staging of goals is best accomplished after the completion of the new Medium Term Plan and the identification of medium-term goals.

b. The Surveys

The KAP surveys have been referred to many times in this document. They were an enormous undertaking during the first year of the project, occupying much AIDSCAP/Honduras staff time. Dr. Bolaños joined the project after they had been planned with substantial input from USAID/Washington. This input was inadequate, however.

Qualitative and quantitative research were conducted during the first year of the project. Quantitative research was conducted before qualitative research, reversing the normal order. This meant that the survey instruments could not be adequately adapted to, or pretested in, each site or target population. For example, the Garifuna survey conducted by ODECO reports incredibly high levels of faithfulness to partners (>90%). Most reviewers were astonished by this figure: the qualitative data report a pattern of multiple partners. Some attribute this to a pattern of stable multi-partner relationships. Whatever the true state, there might have been alternative means of collecting this information which would have provided more valid data. Another example includes CSWs. The qualitative research of CSWs demonstrated a much broader pool of “sex workers” than previously suspected. Also “clients” of sex workers were not really identified in the surveys, and the surveys were conducted with men in the general population. These problems might have been identified in the qualitative component of the research. The compression of these activities and the speed with which the surveys were implemented are partially to blame for these difficulties.

i. KAP Surveys: A major first-year project activity was the development of a KAP-style survey, called CCAP (Conocimientos, Creencias, Actitudes y Practicas de Sexualidad). This style of survey is meant to measure Knowledge, Beliefs, Attitudes, Practices of populations with respect to a special issue. They have become quite popular over the past decade for health communication projects in USAID, collecting information about areas related to promotion. CCAPs are now a conventional part of communication plan development, and are included here as a part of AIDSCAP's technology transfer. The title of these surveys is misleading, however, since, in fact, attitudes have not been measured. Furthermore, the surveys are called for, as part of the evaluation plan, to serve as a baseline for the indicators identified in project documentation. It appears that the surveys have been incorporated into the development of behavior change components, and so a number of items were added to the questionnaire for project development purposes. Although the draft reports recently completed on the surveys are impressive, and demonstrate good attention to many of the details of data collection and reporting, the dual use of the surveys for both intervention development and evaluation have seriously impeded their use in either activity. Also, since the actual research was sometimes contracted out, not all of the organizations equally profited from the exercise.

ii. Problems of the Surveys for Baselines: One difficulty of the CCAPs was their sampling design. All of the surveys used complicated multi-staged, stratified designs. However, almost all used convenience samples at the lowest strata. Although it is difficult to determine exact procedures in the draft reports, the evaluation team's review raised questions about their utility for evaluation. Because convenience samples were used, the sample selected is highly biased in unpredictable ways, and any differences between results from one application of the survey to another might be due to changes in the population sampled, rather than changes in the population's knowledge, attitudes, and practices. In addition, the samples were almost uniformly too small, primarily because of the inappropriate use of the sample size calculator used in the software package EpiInfo 6, which was distributed to all IAs. This calculator determines samples only for simple random designs, not stratified designs. In addition, the IAs did not always appropriately define their sample universes. For example, the CEDEPS study of sex workers treated the universe of sex workers as a single group, when, in fact, it had four separate universes: bordello workers, streetwalkers, U.S. military partners, and men.

The small size of the samples does not only mean that estimates of population parameters cannot be made with confidence (which could not occur anyway due to sampling design), but that further quantitative analysis of survey items cannot take place because of small cell size. The following table outlines some of the difficulties with the surveys. DE refers to design effect (the need to increase sample size when simple random samples are not used); PPS refers to population proportional to size, and Pre-Post refers to the ability to use the samples for comparison in a post-test evaluation design.

Table 7: Problems with the Surveys for Baselines

Organization	Sample Design	DE	PPS	Random	Pre-post?	Size
IHSS	Multistage, three strata: three cities, businesses grouped by economic activity, random sample in 65 sites.	?	Y	Y	Maybe	997
ODECA	Random sample stratified by site and age.	N	N	Y (claimed)	N	320
CEDEPS	Jury sampled for convenience (street walkers, bordello workers, and partners of U.S. Army recruits)—cells too small.	N	N	N	N	97 TS, 59 BASE, 11 bordello, 27 streetwalkers, 128 gay men
COMVIDA CGS	Convenience jury sample, adolescents, sex workers, adult professionals, workers—sample size inappropriately calculated.	N	N	N	N	145 men
COMVIDA	Selected 10% of each site at random, sites selection not described until sample size achieved.	N	N ⁹	N ¹⁰	Maybe ¹¹	134 workers
PRODIM	Jury sampled by geographic area, for women, convenience sampled establishment. For men, not well described, but visited offices during the day and some sites of prostitution by night. ¹²	N	N	N	N	117 women 137 men

These CCAPs should not be repeated, at least for evaluation purposes. Further effort should not be spent on any of these quantitative components except for the study conducted by IHSS. In order to produce a final report, the following steps need to be taken:

- A Summary of the findings should be developed. These results need to be carefully caveated, as they reflect convenience samples.
- A careful description of the design flaws should also be included.
- Further analysis could be conducted on the IHSS sample. This could explore factors in condom use, or risk perception.

⁹Sites not selected for PPS.

¹⁰At last stage, but not for sites.

¹¹For same sites.

¹²Used target population for interventions as sampling universe, rather than estimate of number of sex workers or estimate number of clients.

- The most useful part of the study is the qualitative data. This should be further analyzed before continuing with intervention design. A rapid analysis procedure for the qualitative data is suggested below.

iii. Problems of the Surveys for Project Design: Taken literally, many of the quantitative results of the survey demonstrate that important project components are not needed, i.e., sex workers already use condoms and most men are faithful. Thus, confronted with quantitative survey results which are the product of inadequate design and which contradict local knowledge, common sense, and other research results, the consumer should simply ignore them. For that reason, most of the survey results; should be kept as in-house developmental investigation working documents. They should not be distributed or published as suggested, for example, in the most recent AIDSCAP/Washington site visit report.

iv. Qualitative Research: The qualitative component of the research activity included focus group research. In-depth interviews were called for, but they do not appear to be reported separately. The qualitative component has served a useful purpose to date. The AIDSCAP Officer responsible for developing health education materials has read them and the responsible representative of the IA appears to have read them as well. Many of the IAs themselves participated in these groups and learned from the experience. The written reports are not well analyzed. For example, one report simply lists short quotes from the focus group interviews and provides no comment. Given the investment in collecting this data, it is important that the analysis be completed. It needs to be mentioned that this activity was new to the IAs who often just scratched the surface of information that might have been collected by more experienced qualitative researchers. Completing analysis, therefore, does not refer to a profound analysis of these data, but rather extracting what is available in order to improve intervention design.

In order to complete analysis of the qualitative data in a timely fashion a qualitative researcher should be recruited to provide TA. This TA should consist of reviewing the focus group interview notes (one week) and conducting a workshop with the IAs (three days) to review the findings. This workshop should be narrowly focused, for example, exploring barriers to condom use found in the data. The outcome of the workshop should identify health education needs, behaviors to be promoted, strategies and approaches, and even messages for the program; and the outcome should be presented as a report (one week additional TA).

3. NGO Response

The strategy of the AIDSCAP project is to implement HIV/AIDS prevention activities through NGOs. NGOs and potential activities were identified in project planning documents, and NGOs participated in workshops to prepare proposals for review. The NGOs which were selected by AIDSCAP are:

- COMVIDA/Comunidad Gay Sanpedrana (CGS)
- FSLs
- ODECO
- OFRANEH
- COCSIDA
- Proyecto Desarrollo Integral de Mujer (PRODIM)
- CEDEPS

AIDSCAP also gave grants to the IHSS and COMVIDA (a parastatal of the Municipality of San Pedro Sula), although not NGOs.

The NGO specialist spent two weeks reviewing the programs of each NGO. Overall, NGOs reported a great deal of satisfaction with AIDSCAP support.

There is a general consensus among the IAs that AIDSCAP's intensive training managed, in a very brief time, to provide each institution with basic project development and accounting skills, including an in-depth review of the original proposals, the use of a logframe, Gantt charts, designing evaluation and follow-up plans, and how to prepare a detailed budget. All IAs stated that their administration skills were strengthened by this training, and for many of them, this was the first time that they had accounting guidelines.

However, as can be expected, the rapid implementation of the project produced several concerns. Primarily these involved the rapid pace of implementation of the project, and a desire to have more AIDSCAP support. Several requested that an AIDSCAP staff person be based on the North Coast near many of the projects.

With only a year of implementation it is too soon to review project activities. The NGOs themselves are varied with respect to experience working in HIV/AIDS prevention. There is an important distinction between those NGOs that developed from populations at risk, and those that were developed for the populations at risk. Those with little prior experience needed the time provided by the KAP to familiarize themselves with their population. Several need continued contact, many need to develop more participatory approaches to working with their at-risk populations. NGOs varied widely in terms of experience managing funds and accountability. This issue remains a primary and necessary focus of AIDSCAP's program.

The NGOs identified as having greater knowledge of their target populations are CGS, FSLs, ODECO, and COCSIDA. Institutionally, the MOH (UMIETS), COMVIDA and IHSS have better defined working relationships. PRODIM and CEDEPS are beginning their activities with their target populations.

Interviews indicate that the knowledge of the target population does not necessarily imply that the working relationships are the most appropriate. Factors that indicate more clearly the depth of understanding of the communities where they are working can be summarized in three key concepts: 1) target group involvement; 2) participation in design and implementation; and 3) the authorization of key figures in each community.

a. Involvement

Almost none of the IAs were directly involved with target audience members in the development of their proposals, with the exception of CGS; and almost all the organizations and institutions involved adopted a top-down approach, which is sometimes perceived as coercive. For example, CSWs were offered free medical services for their children if they participated with COMVIDA, PRODIM, CEDEPS, and COCSIDA.

b. Participation

The use of terms such as "participating," "workshops," and "training" to explain working with target populations is overused, and is associated in many projects with methodologies that are not participatory. Many interactions are more like typical school lessons, or lectures—which are sometimes tedious due to the technical language used. Some IAs show films to hook an audience for follow-up discussions—even though these films have nothing to do with the subject. Many use questionnaires that are boring and tiring for the audience.

An area in which participation begins to take shape is the elaboration of educational materials, but here also, only in a utilitarian way—many IAs use those who attend to validate the materials. (PRODIM, COCSIDA, CEDEPS, FSLs.)

This strategy does not generate ideas from the community, but simply asks them to respond. There is the risk of bringing ideas, proposals, messages, images, and solutions from outside of the communities. We have yet to explore what the results and impact of this type of work with the target communities will be, and if these results are the ones behind the achievement of the project indicators.

c. Authorization

Another element to understand how the IAs work with the target communities is through understanding the term "education among equals" that is used in almost all of the projects. All the work aimed towards the CSWs mention that they will identify leaders in the community, who in turn will become peer educators. This often creates resentment, though, since CSWs state that they would prefer to get their information from other sources, such as health educators or nurses.

Examples provided by IAs that work with this theme indicate that the identification of women leaders among the CSWs, due to their intelligence, interest, sympathy, strength, or violence has produced a contrary effect—the rejection of their equals. "What can that whore teach me, if she is like me!" was frequently expressed. The possibility also exists that they get disenchanted with the project, or, in extreme cases, attack the "peer leader." This was discussed by PRODIM, COCSIDA, CEDEPS, and FSLs.

The above example indicates that the IAs need to expand their knowledge of their target populations, and the nature and development of the educational and persuasion tools with which they are working.

Except for FSLs, none of the projects are working directly with persons who live with HIV or AIDS. The inclusion of these persons in sensitivity and training strategies is indispensable to better understanding the perspectives of those directly affected.

d. Behavior Change Communication Interventions and the NGOs

As previously mentioned, USAID documents identified target audiences that the NGOs should work with, and interventions. This makes sense in terms of targeting project resources, but a review of those audiences and the feasibility of interventions with these populations is a sobering exercise.

Table 8: BCC Interventions and NGOs			
Target Population	Seroprevalence	Accessibility	Feasibility
CSWs	High	Bordello-based -- High Others -- Low	Some success in other countries -- condom use
Men	N/A	Low to Medium	Few models
MSM	N/A	Gay -- Medium Bisexual -- Low	Very successful models Few models
Adolescents	Estimate Low	High -- in-school N/A -- out-of-school	Successful models
Workplace	Low	High	Successful models
Garífuna	N/A	Low	No Model

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Although this evaluation does not recommend changing target populations for this coming year, the project, in collaboration with the NGOs, should have more freedom in the medium term to identify target populations and strategies. For example, COMVIDA appears particularly good at developing health education materials, both print and electronic, and should be encouraged to develop these materials for a wide range of target populations. Other NGOs might develop counseling strategies or other face-to-face mechanisms. New populations, such as potential STD clinic users and adolescents, might be added to the mix.

Another interesting feature of the project is provided by the PASCA survey of project NGOs. PASCA notes that most NGOs claim to provide a wide range of services, but many perceive a need for training and TA.

Table 9: NGO Services		
Activity	Number of NGOs	Need for Training
Counseling	7	6
Community	7	4
IEC	7	6
Work place	5	4
Peer education	6	5
In-school	6	5

Most NGOs also claim to be working with a wide range of audiences, but still perceive a need for training and TA.

Table 10: NGO Audiences		
Audience	Number	Need for Training
Women	6	5
Men	6	5
In-school Youth	6	5
Sex workers - women	6	4
Sex workers - men	7	6
STD patients	6	6
Clients	6	6
Out-of-school youth	6	4
Street children	4	4
MSM	7	5
General Public	4	5

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In summary, in order for NGOs to provide solutions for HIV/AIDS prevention, a long-term strategy adapted to each institution will be required. This is a painstaking process that will not end soon.

C. Scenarios (1997-2003)

The evaluation team developed scenarios for EOP 1999 and long-term strategic planning for 2003.

The scenario exercise laid out best possible outcomes that might be expected from project interventions. The exercise was based on available data about the epidemic, and is subject to revision as accurate surveillance data becomes available. This section is broken down into three topics: 1) State of the Epidemic; 2) Surveillance; and 3) Response. Barring breakthroughs in vaccine development or other interventions, such as an acceptable female microbicide, the following goals are proposed:

1. 1999

a. State of the Epidemic

- Prevalence of HIV is stable or declining in the high risk populations in the project areas addressed by the IAs.
- STDs declining in the high risk populations addressed by the project, and are stable in all other populations.

b. Surveillance

- HIV seroprevalence in high risk populations addressed by the project are known.
- The sentinel surveillance system for HIV and STDs proposed for the Ministry is in place, well supervised by the Ministry, and provides reliable data.
- HIV cases will need to be consistently and correctly reported to the Ministry. This will entail follow up of seropositives and ARC cases, and enhanced training of public and private sector physicians and laboratories to improve reporting.
- Behavioral data about practices that transmit HIV are collected periodically through surveys and qualitative research is collected. The major survey activity may be the EOP evaluation, although brief surveys and qualitative research will be conducted to explore

particular topics, e.g., changing sex worker or client practices, changing patterns of IV drug use, etc.

c. Response

- IHSS and MOH services and other activities are integrated. Examples of such integration are:
 - The IHSS and Ministry adopt common STD treatment regimens
 - The IHSS utilizes Ministry materials and expertise
 - A common reporting system is developed and used.

Donor response coordinated:

- A separate STD/HIV donor coordination mechanism is developed and used.
- The MOH can effectively develop, field, and evaluate interventions
- The STD/HIV Division fully and appropriately staffed, collaborates with other MOH divisions and the Health Regions
- Sexuality, safe sex, and STD education are institutionalized in project area schools
- Condoms are widely and cheaply available
- Small group counseling, skill training, peer outreach, counseling and testing, hot lines, media programs, and community interventions tested in project interventions
- Special programs developed for gay and bisexual men
- NGOs provide fee-based services to special populations, monitored by the MOH
- Community-based organizations such as PTAs involved in AIDS prevention in the project area.

2. 2003

a. State of the Epidemic

- Prevalence of HIV is stable or declining in all populations
- Care is a major focus of the health system as the number of cases grow
- Blood supply continues to be well protected, IV transmission negligible
- STDs declining in all populations.

b. Surveillance

- We know the seroprevalence of HIV within the general population and special populations—CSWs, MSM, etc.
- Population-based sentinel surveillance system is in place, supervised by the Ministry—includes HIV and STDs—involves Ministry and certain NGOs
- HIV positive cases are consistently and correctly reported to the Ministry
- Behavioral data about practices that transmit HIV are collected periodically, both through the EFHS, other surveys, and qualitative methods

c. Response

- Nation has an integrated response: MOH, IHSS, donors
- MOH can effectively develop, field, and evaluate interventions
- Sexuality, safe sex, STD, and other interventions such as anti-IVDU education institutionalized in all schools
- Condoms widely and cheaply available
- Syndromic STD treatment is integrated into the health system, and is widely practiced
- Vertical maternal transmission is reduced
- Small group counseling, skill training, peer outreach, counseling and testing, hot lines, media programs, and community interventions are available
- Special programs for gay and bisexual men implemented
- NGOs provide fee-based services to special populations (monitored by MOH)
- Community-based organizations, such as PTAs, are involved in AIDS prevention nationally.

4. Conclusions and Recommendations

A. General Recommendations

Recommendations for the Mission

1. The Mission needs to revise its indicators for HIV/AIDS prevention. The recommended indicators are:
 - 3.E Seroprevalence in CSWs in the San Pedro Sula UMIET and in women attending the antenatal clinic in Catarina Rivas Hospital in San Pedro Sula.
 - 3.3b Increased rate of condom use in most recent act of sexual intercourse defined as "at-risk."
 - 3.3d Increased proportion of health facilities in project areas assessing and treating STDs syndromically.
2. The Mission needs to coordinate support from other resources to assist AIDSCAP to achieve these new targets:
 - a. In order to resolve issues with current surveillance activities, a consultant should be identified immediately to review the available data, data collection procedures, and to guarantee that all equipment and reagents are available so that 1996 data can be collected in November and December. The Mission should take advantage of Centers for Disease Control and Prevention (CDC) resources to review and improve surveillance activities.
 - b. The regional PASCA project can provide training and support to the NGOs.
 - c. A regional social marketing of condoms project can also assist the project to achieve its targets.
 - d. Finally, a mechanism for routine coordination of donors and senior Ministry staff for STD/HIV/AIDS is recommended. Regular meetings should be convened with Dr. Enrique Zelaya, Director General of the Ministry responsible for the STD/HIV/AIDS Division; other Ministry staff; AIDSCAP; and USAID.

3. In collaboration with AIDSCAP/Honduras, the Mission needs to develop a new annual work plan for the entire period of October 1, 1996 - August 31, 1997 (one month before the end of the worldwide contract). AIDSCAP/W is requesting that all field offices terminate all sub-projects by April 30, 1997, and all offices to close by June 30, 1997. AIDSCAP/W is providing a one month cushion for these dates. Still, this will present an unfortunate gap in the project. The Mission has already extended the Honduras delivery order through September 1997.
4. The Mission also needs to intervene with AIDSCAP/W to reduce end of (central) project closeout activities.

Recommendations for AIDSCAP

1. AIDSCAP has had a very successful launch in Honduras. Three substantive areas are foci of the project and warrant continued strengthening. These are:

- Surveillance
- Syndromic STD Treatment
- Behavior Change Communication

Technical Assistance (TA) will continue to be required in all three areas. This TA should be carefully selected to provide continuity for the project and NGOs through the entire life of the project.

2. In order to achieve project results, AIDSCAP must support the Ministry of Health's Division of STD/AIDS. Two actions are recommended: 1) assist the Ministry to develop a new Medium Term Plan this fall; and 2) provide long-term technical, on-site support.
3. The local AIDSCAP entity needs to make the transition to direct Mission support for 1997 - 1999. This involves several actions for AIDSCAP:
 - AIDSCAP/Honduras needs to become a registered Honduran PVO as quickly as possible, so that USAID can continue to fund the project for an additional two years, and so that there is no gap in support.
 - Due to the transition to the longer-term, four-year project, AIDSCAP/Honduras needs to develop new indicators and a plan for the remaining three years. For 1996-97 they should develop a detailed one year work plan.
 - To measure impact, KAP surveys were proposed for 1997. These need not and should not be conducted now. New evaluation plans need to be developed.
 - NGO subcontracts were written within the guidelines of the old logframe indicators. These need to be modified.

4. USAID/W and AIDSCAP/W should reduce the reporting obligations for end of project and end of contract activities. Given the new results framework, some obligations included in the work plans should be dropped and new benchmarks developed.
5. The new approach and results framework will require some reprogramming of project activities. Although wholesale changes in NGOs, target groups, or strategies are not recommended in the next year of the project, the new indicators and results orientation and expectations for 1998 impact require that project activities give emphasis to:
 - Syndromic management of STDs and improving health seeking behavior for STDs in the Project's area of influence: Health Regions Metro, 2, 3, and 6
 - Improved surveillance in the four Regions
 - Behavior Change Communication, both in assisting the MOH at the national level, in the four project Regions, and in the project NGOs.
6. Behavior change efforts should now focus on careful development of communication interventions. These should not be rushed. The qualitative data provided by the surveys conducted in 1996 and the results of the KAP surveys provide an important resource for intervention design. As soon as possible, these data should be reviewed by an experienced qualitative researcher with experience in HIV/STD behavioral change communication intervention design. In a workshop with the IAs these data can be reviewed and used in intervention strategy development and design.
7. NGOs and IAs will continue to need close monitoring and support. Many are located on the North Coast in San Pedro Sula and La Ceiba. An AIDSCAP staff person should be hired or moved to a satellite office in San Pedro Sula to provide this support.

Long-term Recommendations

1. Population-based HIV/STD seroprevalence studies and behavioral research need to be conducted in high risk groups such as CSWs, MSM, Garífuna, and other groups that might be identified. With respect to behavioral research, very little is known about the sexual practices glossed as bisexuality, and whether they play a role in the epidemic. If they do, the people who practice them may prove extremely difficult to reach, and research should be conducted to test pilot interventions. In general, these special studies will be important for measuring program impact and for design of future interventions.
2. Interventions to reduce vertical transmission, such as the use of AZT or other antiviral drugs, and improved delivery for seropositive mothers should become part of the HIV/AIDS prevention program.

3. Current Honduran national policies related to decentralization of the state involve municipalities in developing health interventions, including HIV. A wide range of prevention interventions for the general public involving the municipalities, communities, local schools, and other civic organizations throughout Honduras need to be developed. Implementing this policy will be an important challenge.

B. Specific Comments

1. Comprehensive technical assistance will be required to strengthen both HIV and STD surveillance and AIDS case reporting. This assistance will need to include design of surveillance systems, selection of appropriate population samples, laboratory quality assurance, and information systems for data management and analysis.
2. AIDS and HIV case reporting is unreliable as an indicator of the epidemic in Honduras. A solid base has been developed for sentinel surveillance in San Pedro Sula and Tegucigalpa. However, technical assistance is required to improve study design and site selection. It will be particularly important for the surveillance system to include working persons receiving care from IHSS, especially in San Pedro Sula.
3. STD case reports and sentinel surveillance are unreliable as indicators of STD prevalence. Efforts are needed to ensure an adequate supply of reagents for syphilis screening, and to conduct quality assurance to ensure reliable testing. Sentinel surveillance for STD can be combined with surveillance for HIV among antenatal mothers and CSWs, and could be extended to develop information on prevalence in men.
4. Syndromic STD management is poised for introduction. The initial focus on the four STD clinics in the priority project areas is appropriate for gaining experience, but the challenge will be to ensure that personnel in area health centers are adequately trained, and that the necessary medications are available. Continued technical assistance for training and logistics management will be required. It will also be necessary to identify a continuing source for the medications necessary to support syndromic management.
5. It does not appear that San Pedro Sula has received technical resources and support proportional to the magnitude of the problem in that health region. In particular, better coordination with, and involvement of, IHSS in San Pedro Sula is required to adequately address STD treatment for the populations at highest risk in Honduras.
6. The new syndromic approach needs to be broadly promoted. Educational efforts currently being mounted might usefully promote syndromic therapy for STDs in the general population by announcing the existence of the new regimen and drugs available in health clinics. Training in syndromic STD management should be extended to *medicos de*

empresas, to IHSS facilities that provide health care for working men, and to private providers and even to pharmacists; although this latter group is unlikely to be acceptable to the Colegio de Medicos.

7. The introduction of syndromic STD management met resistance in other countries until its effectiveness was validated locally. Studies to validate syndromic management and to establish its cost effectiveness could be conducted to help persuade both policy makers and providers of its effectiveness, and to improve the chances that it will be sustained.
8. STD and HIV prevalence information should be developed (using unlinked anonymous surveys) for MSM and Garífuna populations to determine the need for, and effectiveness of, interventions with these groups.
9. The STD/HIV Division needs assistance in the immediate future if surveillance, STD management, behavior change communication, and NGO oversight, as proposed in the AIDSCAP project, is to be successful. USAID should permit AIDSCAP to provide the Ministry with a full-time staff person to assist in the activities of the Division. The ideal candidate would be an HIV prevention specialist with significant management and administrative expertise. The Division also needs expertise in the areas of behavior change communication and behavioral research. The scope of work of this staff person should be limited to activities specified within the AIDSCAP delivery order.
10. USAID, through AIDSCAP, should support the development of a new Medium Term Plan during the last quarter of 1996. This will involve convening international donors and agencies, such as PAHO; UNAIDS; EEC; and JICA; other Ministries and sectors; such as Education and IHSS; and inviting expert participation when needed (strategic planning, surveillance, evaluation, STDs, public health communication, and other intervention areas such as testing and counseling).
11. AIDSCAP should continue to work closely with the Division of STD/HIV and the Division of Education in the Ministry to develop effective, actionable messages, and to see communication products as a part of a systematic strategy of targeting, promoting, and evaluating health communication. Technical assistance is required in the area of public health communication: to provide training to Ministry staff and senior Ministry in health communication; to provide assistance in actual design, development and evaluation of materials and programs; and to provide model guidelines for development of diverse interventions such as small group counseling.
12. The KAP surveys should not be repeated, at least for evaluation purposes. Further effort should not be spent on any of these quantitative components except for the study conducted by IHSS. In order to produce a final report, the following steps need to be taken. A

summary of the findings should be developed. These results need to be carefully caveated, as they reflect convenience samples. A careful description of the design flaws should also be included. Further analysis could be conducted on the IHSS sample. This could explore factors in condom use, or risk perception. The most useful part of the study is the qualitative data. These should be further analyzed before continuing with intervention design. In order to complete analysis of the qualitative data in a timely fashion a qualitative researcher should be recruited to provide TA. This TA should consist of reviewing the focus group interview notes (one week) and conducting a workshop with the IAs (three days) to review the findings. This workshop should be narrowly focused, for example, exploring barriers to condom use found in the data. The outcome of the workshop should identify health education needs, behaviors to be promoted, strategies and approaches, and even messages for the program; and the outcome should be presented as a report (one week additional TA).

13. Data should be substituted from the EFHS male survey to respond to indicator 3.3b. The survey should be repeated in several years time.
14. Indicator 3.3c can be reported from the male module of the EFHS, and data on this indicator could be collected in the future. However, as a reportable indicator we recommend that it be dropped.
15. Indicator 3.3d should be changed and expressed as the proportion of health facilities correctly assessing and treating STD patients with the syndromic approach.
16. NGOs need support in protocol development, fund raising, and better access to information resources. This might be accomplished in collaboration with the PASCA project.

ANNEXES

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Annex 1
Questions and Answers

TEAM LEADER Questions

1. Behavioral Change Communication Campaigns (BCC)

- 1a. Are the strategies and campaigns appropriately designed for the target audiences?
Are the campaigns reaching the target population?**

The behavioral change campaigns have not yet been initiated. Focus group and survey research has been conducted and is currently being analyzed. Most of the first year of this project component was spent in formative research. Several health education materials are in the design phase in NGO's and in AIDSCAP. It is too soon to review this component. AIDSCAP staff promote a development communication approach focusing on health education materials as a component of behavior change strategies that is both appropriate and familiar to the Ministry. How well this approach has been transferred to the NGOs is yet to be seen. AIDSCAP staff acknowledge a continuing need for TA from outside sources to bolster their capacity to develop and implement this component.

- 1b. To what extent are the materials and messages successful in increasing the perception of risk of HIV infection among individuals in core groups and decreasing their high-risk sexual behavior?**

Too soon to tell. This question is perhaps misguided. First, it should be mentioned that even if the campaign had been initiated, one year or even two years may not be sufficient to engender changes in deeply seated behaviors. More importantly it is rarely "materials" and "messages" that bring about behavior change by themselves, they are simply tangible markers of what should be a comprehensive strategy that responds to identified needs. This strategy may involve using these materials in small groups, or as reminders of information or services available elsewhere. Several strategies, such as promotion of condoms for sex workers are identified in project documents. It remains to be seen if barriers to condom use in this population, for example, which are often associated with client behavior, will be overcome. Structural interventions might also be considered, such as 100% condom brothels.

- 1c. To what extent are efforts being made to evaluate the impact of the BCC campaigns and materials?**

An original design proposed by AIDSCAP was a simple pretest-posttest design without controls. This design is flawed on two counts. First, there is no control or comparison group. Second, the sampling plans for the KAP surveys were flawed, making the results uninterpretable. Design issues of the pretest will be discussed below.

Issue 1. Relationship of Qualitative and Quantitative Components

Qualitative and quantitative research was conducted during the first year of the project. Quantitative research was conducted before qualitative research, reversing the normal procedure.

Issue 2. KAP Surveys

A major first year project activity has been the development of a K-A-P style survey, called CCAP. This style of survey is meant to measure Knowledge-Attitudes-Practices of populations with respect to a special issue. They have become quite popular over the past decade for health communication projects in A.I.D., collecting information about areas related to promotion. KAPs are now a conventional part of communication plan development, and are included here as a part of the technology transfer that AIDSCAP is responsible for. The title of these surveys is misleading, however, since, in fact, attitudes have not been measured. Furthermore the surveys are called for as part of the evaluation plan, to serve as a baseline for the indicators identified in project documentation. It appears that the surveys have been incorporated into the development of behavior change components, and so a number of items were added to the questionnaire for project development purposes. Although the draft reports recently completed of the activity are impressive, and demonstrate good attention to many of the details of data collection and reporting, the dual use of the surveys for both intervention development and evaluation have seriously impeded their use in either activity. Also, since the actual research was sometimes contracted not all of the organizations profited equally by the exercise.

Problems of the surveys for baselines

One difficulty for the studies was the sampling design. All of the surveys used complicated multistaged, stratified designs. Many used convenience samples at the lowest levels. Although it is difficult to determine exact procedures in these draft reports enough information is provided to raise questions about their utility for evaluation. The following table outlines some of the difficulties with the surveys. DE refers to design effect (the need to increase sample size when simple random samples are not used); PPS refers to population proportional to size, and Pre-Post refers to the ability to use the samples for comparison in a post-test evaluation design.

Table 1: Problems with the Surveys for Baselines						
Organization	Sample Design	DE	PPS	Random	Pre-post?	Size
IHSS	Multistage, three strata: three cities, businesses grouped by economic activity, random sample in 65 sites.	?	Y	Y	Maybe	997
ODECA	Random sample stratified by site and age.	N	N	Y (claimed)	N	320

Table 1: Problems with the Surveys for Baselines						
Organization	Sample Design	DE	PPS	Random	Pre-post?	Size
CEDEPS	Jury sampled for convenience (street walkers, bordello workers, and partners of U.S. Army recruits)—cells too small.	N	N	N	N	97 TS, 59 BASE, 11 bordello, 27 streetwalkers, 128 gay men
COMVIDA CGS	Convenience jury sample, adolescents, sex workers, adult professionals, workers—sample size inappropriately calculated.	N	N	N	N	145 men
COMVIDA	Selected 10% of each site at random, sites selection not described until simple size achieved.	N	N ¹	N ²	Maybe ³	134 workers
PRODIM	Jury sampled by geographic area, for women, convenience sampled establishment. For men, not well described, but visited offices during the day and some sites of prostitution by night. ⁴	N	N	N	N	117 women 137 men

All of the studies, with the exception of the IHSS study used a sample size calculator included in EpiInfo6 inappropriately. For example, the CEDEPS study used a simple random sampling plan when, in fact, it had four separate universes: bordello workers, streetwalkers, US military partners, and men.

1d. Do the project sponsored IEC efforts complement those of the MOH and other agencies? If not, why not, and how can they be made to complement each other?

Communication activities have been closely coordinated with the MOH and UNICEF. An interesting background note concerning UNICEF's contribution is that one of the original USAID trained health educators in the Mass Media and Health Practices Project in Honduras (1980-1983) provided TA for the NGO training workshops. The MOH is depending on the team

¹Sites not selected for PPS.

²At last stage, but not for sites.

³For same sites.

⁴Used target population for interventions as sampling universe, rather than estimate of number of sex workers or estimate number of clients.

put together by AIDSCAP for continued support. However, many Ministry efforts are based on antiquated information methods. With the resolution of issues concerning the Health Education Division in the Ministry of Health that will be part of the Health Sector II Project, an opportunity exists to both institutionalize the development communications approach and enhance the quality of health communication materials.

1e. Is further TA in this area necessary, and if so, why, and what would be the nature of this TA?

All parties have expressed a desire for continued support in this area, and it will be necessary. No Honduras AIDSCAP staff have formal training in the area of health communication. Furthermore, the Ministry (and many of the NGOs) appear to have adopted, an information based approach to developing health education materials. This approach forgets the more than 16 years of formal support provided by USAID to the health education division.

Among the reasons for this problems are:

- Isolation of the health education division.
- Shortages of key personnel with technical qualifications.
- Lack of familiarity at senior and junior levels of the Ministry with more professional health communication approaches.
- The focus on materials and messages, rather than integrated programs.

Formal training, both in the form of support to project activities and workshop training of AIDSCAP, NGO and Ministry staff is required. In addition, TA is required to provide both technical inputs and policy dialogue with senior Ministry staff. A seminar for Senior Ministry policy makers and technical staff, even if for only one or two days, might revivify a communication approach and provide clout for AIDSCAP efforts.

2. Policy Dialogue

2a. To what degree has the project been effective in involving other sectors and agencies?

AIDSCAP has played an important role in involving the private business sector and the national media. In fact, AIDSCAP is the first project in the health sector to establish regular and routine meetings and training sessions with the media. AIDSCAP's role in involving other sectors, such as government, is limited though by concerns from the Ministry of Health that AIDSCAP could become its own lobby, or work around Ministry concerns and issues.

2b. What has been the involvement of the other sectors to date and what efforts should be made to strengthen this involvement?

The business sector has been involved through the IHSS and other NGOs. There appears to be some support in the private sector to establish peer counseling programs.

Collaboration with the media has been very significant. At least once a month, if not more, approximately one dozen print and electronic journalists from the major newspapers and radio devote their own time to attending training workshops and courses about HIV/AIDS and STDs. These journalists are working to involve the owners of the media in HIV/AIDS prevention activities, planning for major promotional events such as World AIDS Day. Needless to say accurate coverage of HIV/AIDS has improved. The journalists see their major job as keeping HIV in the public eye, providing a human face for the epidemic, destigmatizing seropositivity, and raising issues such as sex education that are controversial. Their strategy is to win their organizations over to providing much more free coverage of prevention activities. The program was not contemplated in the original project documents, but was a product of personal contacts between AIDSCAP staff and the journalists. This is an important initiative that needs to be continued.

A workshop with religious leaders has also been held that will yield significant benefits.

2c. What progress has been made to promote the passage of national legislation to enhance HIV/AIDS prevention, and to assure that HIV/AIDS prevention remains a priority among key leaders in government and the private sector?

A proposal "Proyecto de legislation para los Derechos Humanos VIH/SIDA" has been developed with the assistance of the Central American PASCAP project by a committee of the national legislature. AIDSCAP has supported these efforts, but is constrained, by Ministry request, from closer involvement. This is a sensitive position for AIDSCAP. To meet its purpose of bridging the Ministry, USAID, and the NGOs, it should maintain its current low profile in this arena.

2d. What further efforts are necessary in the policy dialogue area?

Continued efforts to sensitize institutions to the HIV/AIDS STD problem are required. Two institutions in particular, the Ministry of Labor, and the Armed Forces, seem reluctant to embrace the implications of the epidemic.

It also appears that policy dialogue with other donors will be required. Explicit policies from the UN, the European Community and the Japanese government do not exist. UN representatives state that they are waiting for Ministry direction. UNAIDS is not yet operational in country, and even when it is, its \$30,000 annual budget is unlikely to provide it much clout. GTZ has a presence, but its project has only just started and is involved in coordination and the distribution of already printed educational materials (IPPF AIDS Manual). The Japanese have proposed a

health education center, but the document does not make clear what need in the epidemic this fulfills. The Dutch have supported several NGO activities in San Pedro Sula, and appear the most sophisticated European donor. UN and European Community, as well as other foreign donor assistance is coordinated by Dr. Jorge Fernandez, former national program director and a well respected figure in the field of HIV/AIDS. Dr. Fernandez has a close working relationship with the AIDSCAP project and should be involved in future developments of the project.

The Ministry needs to maintain HIV/AIDS as a high profile program. First, improved surveillance will demonstrate a growing problem, to which the Ministry needs a response, secondly, the new syndromic approach means that the Ministry will become much more involved in treatment. The main report lists the dismaying losses of the central and regional HIV prevention program. Specialists need to be identified and recruited to the Division, or staff sent for training. Perhaps the MPH program needs to be revived, with a focus on HIV/AIDS. Along with the HSII Project, a large number of issues will need to be negotiated with the current government, and then with the new government in 1998.

3. Project Management and Coordination

3a. To what extent is the project coordinating with the NGOs, IHSS, and others, and with the central and regional coordinating committees? Is the concept of El Ministerio como rector de salud, pero no ejecutor de todo, being implemented in accordance with the norms of the Modernization of the State?

AIDSCAP has, for the most part, maintained excellent relations with other collaborating organizations. One factor is the personality and working style of the Office Director, Dr. Jorge Higuero Crespo, who has occupied senior positions in the Ministry for more than a decade. A wide network of professional contacts and long-term working relations permits an easy and fluid collaboration. Dr. Crespo and his staff and Ministry counterparts maintain daily contact. The Ministry has become so dependent on AIDSCAP, in fact, that it wished AIDSCAP were located in Ministry headquarters or nearby.

Relations with NGO subcontractors, is somewhat different. This is covered in the section on NGOs below. As the organization with fiduciary responsibility its presence has been felt in many of the NGOs. With regard to the program, several of the NGOs have expressed concern about the constraints of AIDSCAP's support (a good thing) and the pace of development of the projects. This is driven by contractual concerns, however, that need to be modified as the project makes the transition to independence from the central contract. By establishing realistic expectations over a four-year life of project, rather than a two-year one, this pressure will be alleviated. By expanding the scope of work to deal with other NGO concerns as well, these relations will be improved.

The second half of this question refers to Ministry performance. The Division of HIV/AIDS has adopted a supervisory role in many of AIDSCAP's activities, and has focused its efforts on

traditional concerns, such preparing new norms for syndromic treatment of STDs. The question is actually moot, since currently the HIV/AIDS Division, having lost three professionals, is not capable of either adequately supervising or implementing the program.

3b. Is the project's monitoring and evaluation system responsive to the needs of its users? How well is it functioning? Provide examples of how program activities have been modified based on the monitoring and evaluation system.

This component is in development. One form of monitoring is well developed, however. That concerns NGO finances. The potential for theft and fraud is high in many of these organizations, and one, ODECO, has already been the subject of an IG's investigation. A tremendous amount of AIDSCAP staff time and effort is spent reviewing financial documents. It will be years before some of these organizations develop the professionalism to successfully and responsibly manage donor funding.

3c. To what extent have the baseline assessments been used to design interventions among the targeted population?

To be seen. An activity to analyze the qualitative data and develop interventions is proposed above.

3d. Are the implementing agencies in compliance with reporting requirements of the project? Are annual work plans of the project being submitted and approved by the National AIDS Control Program (NACP), MOH and USAID in a timely fashion?

Yes. Second annual work plan just being completed as this evaluation is terminating.

4. Design and Achievement Issues

4a. To what extent have the project goals and objectives been achieved to date? Which results and benchmarks under the first phase may not be achieved?

The AIDSCAP project is currently using a set of outdated indicators to measure progress that are part of its logframe. The new indicators that USAID is using in its R4 need to be substituted. However, since AIDSCAP results may need to be reported to Washington, those indicators are reviewed below. The logframe referred to here is the Spanish language logframe used by the AIDSCAP project.

Although this question uses the terms results and benchmarks, part of the new reengineered process, the project was developed using the logframe approach. This logframe contained many of the old GPA indicators. The expected end of project date also coincided with the EOP of

AIDSCAP, giving the project a two-year life. It is unrealistic to assume that a behavior change project could achieve an impact in this time frame. Given USAID's intention to extend the project to 1999, the logframe indicators will be reviewed:

Objectives:

1. Prevalence of HIV maintained at 0.3% or less in Tegucigalpa, 1.5% or less in Region 2, 3.6% or less in Region 3; and 1.4% or less in Region 6 [CPI 10]

This is an unrealistic set of expectations. Current rates are higher in almost all regions, and it is unclear if this general population figure will be affected by program activities. Since expectations are that the percentage of antenatal women who are HIV+ will continue to increase each year, an extremely ambitious target would be current levels. Furthermore, in setting new targets, USAID and AIDSCAP should take into account real targets. How many, and what population of women need to be reached to achieve this goal?

2. Prevalence of syphilis is maintained at 15% or less. [CPI 8]

It is difficult to determine the true rate for syphilis. Once the sentinel surveillance system is in place and functioning this indicator should be changed to: a) reflect only target populations for the project; and b) represent a stable proportion.

3. The prevalence of HIV is maintained at 5.5% or less in the metropolitan area of Tegucigalpa; 19.8% or less in SPS in sex workers.

As in 2 above. The second of these indicators reflects a changing population, i.e. what kind of sex worker? We recommend that when the new indicator 2 is reformulated, this indicator be dropped.

Goals:

These indicators are CPI 1, 3, 4, 5, and 6. These are behavioral indicators that were to be derived from the KAP surveys conducted for the project. As discussed above these surveys, with the possible exception of the IHSS survey, cannot be used to measure these indicators. Instead, a post-only design is proposed, as above. The indicators should be changed to reflect not pre- and post differences, but post-only exposed and unexposed groups. In translation to a results framework and in addition to numerical outcomes, qualitative targets, (i.e., historical and anecdotal information) may be used to assess the more difficult-to-measure impact of the projects on the target population. Although not providing a rigorous and precise measure of outcomes it will permit a broader capture of program effect.

1.1 CPI 6

This indicator requires that 80% of the target population with STDs receives treatment with the new syndromic protocol. Measuring this indicator will require a careful definition of the target population. In many cases the target population is broadly defined, such as male clients of sex workers. This indicator should be reconstructed to:

- a. Reflect the proportion of health services correctly providing syndromic therapy.
- b. Reflect the proportion of a well-defined target population such as the population of workers in several workplaces involved in the project, and the population of registered CSWs involved in project activities.

1.2 CPI 7

This indicator requires that 50% of the target population with STD receives counseling. Again, as in CPI 6, this indicator should reflect proportion of clinics providing adequate counseling, and proportion of well-defined target cases.

1.3 80% of the target population is conscious of or has access to improved STD services.

As above, this indicator will be difficult to measure. Its significance is unclear. "Conscious of" or "has access to" are quite different. This might be changed to:

1.3 Target populations in the workplace, sex workers, and MSM have access to improved STD services (access defined as a facility within five km or one-half hour of bus or other transport).

Since providing these services is an explicit part of the STD program, this indicator might conveniently be dropped.

1.4 At least 25,000 condoms a month be distributed from each of the four clinics that participate in project activities at the end of the second year.

Since condoms are being distributed from many sites, this indicator should be part of a set of indicators concerning condom logistics, distribution, and use that needs to be formulated. The project is currently distributing 50,000 condoms a month from more than the UMIET sites. This indicator is due to be dropped in 1997. However the replacement indicators require annual KAP studies. We strongly recommend that this be reconsidered, since the NGOs do not have the capacity to conduct these studies. See the discussion of the KAP surveys for further details.

1.5 One training session a month conducted by clinic staff at the start of the second year.

This indicator along with 2.1, 2.2, 2.3, and 2.4 begins a series of health communication indicators that are: a) logistic; and b) not concerned with impact. If the posttest-only evaluation plan is adopted, a broader range of measures of health communication impact should be adopted. These indicators would measure exposure to program, recognition of content, knowledge of content and reports of behavior change. This indicator requires that at the start of the second year of the project these training sessions are being conducted. This is currently not the case, and this indicator is not yet achieved

1.6 N.B. 1.6 not described in logframe document.

The referral system is not yet operational, and a quantitative target for this indicator reflects epidemiological variables that are not controllable. This indicator should be reconstructed, if required, to :

Target population using STD services are correctly and appropriately referred.

Establishment of a National STD Committee

No National STD committee has been organized, nor is one recommended by this report. Instead, STDs such as syphilis should be incorporated in the national HIV/AIDS committee. This committee is fairly moribund at present and will need to be reinvigorated.

Indicators for 2 include the numerical and logistical outputs of this health education component. These outputs are incorrectly identified as indicators. In reengineered language, these are benchmarks masquerading as results. Results here should be reformulated as behaviors which can be measured at EOP.

These indicators represent condom logistics, 3.4 represents condom use. With the exception of 3.4 (which has not been measured) and 3.5, the project appears to have satisfied these indicators.

These indicators reflect assistance to the implementing agencies, and have all been met. It is unnecessary to have proportional indicators here, i.e., 80 percent of the IAs implement HIV prevention programs, since all are involved. It is unclear if these set of indicators are required at all.

These indicators involve raising the consciousness of the general population concerning HIV, and involve distribution of the socioeconomic impact study. This study is somewhat dated, however, and appears to have created confusion about the path of the epidemic. It predicts a

much higher number of cases than appears to be found. It's widespread distribution should be stopped. These indicators should reflect instead the relationship AIDSCAP has forged with the press and other media, and policy dialogue.

- 4b. If the results and benchmarks are not being achieved, why not? What activities should be continued as planned, and what activities should be discontinued. And why?**

This question is discussed in terms of each indicator, above.

- 4c. Based on the findings of the Program Review, the base line studies conducted by the project, and other studies, what new activities, if any, should be conducted under the second phase of the project? Justify these new activities in the context of the evolution of the HIV epidemic in Honduras.**

New 1999 goals are described in the body of this Report. At the moment (1997 goals) it is recommended that the project focus on developing interventions in the target populations selected with some expectation that the audiences might be expanded to include adolescents. Other changes to the project to reduce AIDSCAP/W EOP closeout requirements are discussed in the report as well. Expectations for the path of the epidemic, program goals, and expectations for this period are described in the main body of the report in the Scenarios section. In general, surveillance and STD programs will need to reach the entire population in the Health Regions in which the project is working, and several other target audiences, such as adolescents, will need to be involved as well. During these two years of the project some identification and culling of NGOs will undoubtedly occur.

- 4d. Propose project results and benchmarks for the period September 1997 through September 1999, technical strategies for achieving the results and benchmarks, and administrative mechanisms for supporting the delivery of these strategies. Use the HIV/STD indicators in the results framework of the Health Sector II extension as a starting point for these results and benchmarks.**

See Scenarios section in the body of the report.

The new indicators proposed are:

- 3.E Seroprevalence in CSWs and women attending antenatal clinic.**
- 3.3b Increased rate of condom use in most recent at-risk intercourse.**
- 3.3d Increased proportion of health facilities assessing and treating STDs with syndromic approach.**

- 4e. Is the local office sufficiently maturing to function independently after August 1997? If so, what would be the best way or mechanism for them to continue to function independently? If not, what additional actions need to be taken, including technical assistance, to achieve this maturity?**

The new office is mature enough administratively and managerially to function independently. It should make the transition to an independent NGO as quickly as possible. The project will require technical TA in the short term (until 1997) and beyond. A lawyer should be retained to assist in this effort.

- 4f. What are the staffing needs to achieve the new results?**

Within the office itself, no new staffing needs are required. However, in order to achieve project results, the HIV/AIDS Division will require assistance. USAID should consider hiring a short-term advisor through AIDSCAP to work in the Division's office. At the same time, policy dialogue needs to be conducted with the Ministry to provide additional trained staff as well. It is recommended that an additional staff person be sited in San Pedro Sula or La Ceiba to provide additional support to the NGOs.

- 4g. Should the project reassess its geographic focus and emphasis on core transmitters, or should it stick with these groups while other agencies support strategies more directed towards the general population? Where is USAID's competitive strength to contribute in this area?**

In the short term, for reasons of good management, the project should continue its focus on the same target groups in the subcontracted projects. However, the project should consider providing TA or support for other initiatives being conducted by the Ministry and/or the NGOs. For example, since adolescents have become targeted by the Ministry and many NGOs, the project should be permitted to assist in formative research and the development of educational curricula, or peer outreach programs. It needs to place more emphasis as well on surveillance.

USAID's competitive strengths in this area are:

- surveillance and investigation
- STDs
- health communication

These competitive strengths can be used to strengthen Ministry, IHSS, and NGO programs and activities no matter the target group.

Beyond 1997, the project should consider the changing pattern of the epidemic, and consider shifting resources to targeting men, MSM and bisexuals, for example.

4h. What should be the project's relationship to the Central American HIV/AIDS Prevention Project?

PASCAP can serve a role in the AIDSCAP project. First, as a regional project it can collaborate with political authorities in a way that AIDSCAP cannot. Secondly, when AIDSCAP makes the transition to an NGO, PASCAP can provide services. PASCAP may be a potential source of health communication TA, for example, or work with selected NGOs. PASCAP provides linkages to other Central American NGOs.

4i. Provide timelines showing all critical events that must occur during: 1) the transition period until the termination of the AIDSCAP central contract (September 1996 through August 1997); and 2) the implementation period of the extension of HIV support activities (September 1997 through September 1999).

Table 2: Timeline	
Event	Timetable
For USAID	
Creation of AIDSCAP NGO	By July 1997
Identification of New Indicators	By January 1997
New Evaluation Plan	By February 1997
Development of Project Extension	By June 1997
New Delivery Order	By August 1997
For AIDSCAP/MOH	
Refunding IAs	By October 1996
Surveillance Operational	By January 1997
New Condom Logistics System in Place	By December 1996
Communication Interventions	By November 1996
STD Drugs Available	By November 1996
Medium Term Plan Developed	By December 1996
Donor Coordination Mechanism Established	By November 1996
Syndromic Treatment Training	Continuously
BCC Training, Review	Continuously
IA Monitoring	Continuously

STD/HIV Surveillance and STD Treatment Specialist

5. To what extent are data on HIV and syphilis seroprevalence being collected in and reported by sentinel sites in Tegucigalpa, San Pedro Sula, La Ceiba, and Comayagua?

San Pedro Sula. Unlinked anonymous surveys of HIV and syphilis seroprevalence have been conducted annually since 1991 among antenatal women and commercial sex workers (CSWs) attending the Dr. Miguel Paz Barahona health center in San Pedro Sula. The most recent sample of 200 CSWs and 400 pregnant women was obtained in November-December of 1995. The unlinked samples are tested in the health center laboratory for VDRL, and submitted without identifiers to the regional laboratory, where they are frozen, stored and subsequently tested for HIV. Results of the HIV seroprevalence are reported annually. No cases of syphilis were reported among the antenatal mothers. In CSWs, syphilis seroprevalence was 14% in 1992, 3% in 1993, and 1% in 1995. HIV seroprevalence is presented in Table 1. This sentinel surveillance has been supervised by Dr. Miguel Eduardo Umaña, who left the program several months ago. It was viewed as a five-year project, and there are currently no plans to continue the survey.

Table 3: HIV Seroprevalence at Sentinel Sites, Honduras			
Site	Year	HIV Prevalence (95% CI)	
		Antenatal	CSWs
San Pedro Sula	1991	3.6% (2.0-6.0)	14% (9.2-20.1)
	1992	2.8% (1.4-4.7)	16.3% (14.2-26.4)
	1993	2% (0.9-4.0)	12.5% (7.8-17.1)
	1994	4% (2.4-6.2)	12.1% (8.1-17.2)
	1995	4.1% (2.4-6.4)	20.5% (15.4-26.4)
Tegucigalpa	1992	0.3% (0.06-0.6)	
	1996	1.03% (0.5-1.84)	
Tela	1994	1.4% (0.6-1.96)	

Tegucigalpa. Sentinel surveillance was recently established with the CESAMO Las Crucitas, designated as the study site for prenatal women. Once it is operational, the UMIETS (Unit for Integrated Management of STDs) at Villa Adela in Comayagua will conduct sentinel

surveillance among commercial sex workers. In 1992, an unlinked anonymous survey was conducted among 1,292 women attending six health centers. A second study of HIV and RPR seroprevalence was recently completed among 780 pregnant women from Las Crucitas. Syphilis seroprevalence in these antenatal mothers increased from 0.8% in 1992 to 1.41% in 1996, and HIV seroprevalence increased from 0.3% to 1.03%.

Comayagua. A protocol has been developed for HIV surveillance among antenatal mothers and CSWs, but a study has not yet been initiated. Information on RPR prevalence is available only from laboratory reports on testing among pregnant women; coverage has been incomplete, in part because of reagent shortages. Fifteen (0.2%) of 5873 women were reported positive from Region 2 in the first semester of 1996, compared to 50 (0.9%) of 5,453 in the first semester of 1995.

La Ceiba. The antenatal survey scheduled for 1996 at the Tela Hospital, sentinel site for Region 6 (La Ceiba) was canceled because there were insufficient laboratory technicians. The 1994 anonymous survey among 711 pregnant women from Tela demonstrated an HIV seroprevalence of 1.4%. Syphilis seroprevalence information is collected from all antenatal testing. There has been significant variation in prevalence from year to year, which may be due to incomplete screening (Table 2).

Table 4: Antenatal Syphilis Screening - Sanitary Region 6				
Year	Births	No. Tested	% Tested	% Positive
1990	19,761	5,508	28	0.9
1991	18,568	7,678	41	1.2
1992	19,812	9,868	51	9.2
1993	18,805	9,754	52	7.0
1994	22,745	8,633	38	7.5
1995	17,427	9,410	54	3.5

6. What are the obstacles to the opportune collection, dissemination, and use of sentinel information? How can these be overcome?

Honduras has devoted substantial attention to implementing sentinel surveillance, which can be strengthened to provide more reliable information for monitoring the epidemic. The current sentinel surveillance consists of periodic cross-sectional surveys from a single health center.

Several conversations indicated an intention to expand these cross-sectional surveys to other sites (e.g., Santa Rosa de Copán, Trujillo). While these yield interesting information, such surveys from a single health center cannot be readily generalized to the region, and cannot be relied upon to monitor changes in the epidemic or the impact of interventions. For example, in San Pedro Sula, where efforts have been most extensive, pregnant women who are either workers or spouses of workers receive their prenatal care at IHSS-affiliated health centers. These represent a substantial proportion of pregnancies in the region which are not reflected in the antenatal survey. Additionally, the observed prevalence rates are not comparable between sites because the inclusion criteria are inconsistent. San Pedro Sula obtains specimens from all pregnant women, while Tegucigalpa excludes pregnant women who are also sex workers. Finally, the observed low prevalence of syphilis is surprising in view of the HIV prevalence; this suggests a need for a quality assurance mechanism to ensure the accuracy of syphilis testing.

Sentinel surveillance can provide the best opportunity to monitor changes in the epidemic in Honduras, but technical assistance is required to design a uniform protocol, to select the appropriate sites and frequency for sampling, to monitor implementation, and to ensure that adequate personnel and resources are available to conduct the testing. Ideally, the antenatal surveys should include specimens from several sites in metropolitan areas, including IHSS clinics. To ensure consistency, it would be helpful for one person (or team) to coordinate activities at all sentinel sites, and if logistically feasible, submit all the specimens to one regional or central laboratory for processing and data input. This laboratory could also repeat the syphilis testing performed by health center laboratories to verify their proficiency. The frequency of serosurveys will also depend on the observed prevalence. With the low prevalence observed at some sites (e.g., Tegucigalpa), it may require several years between surveys to detect significant differences. Focused cross-sectional surveys could be used (as they have in the past) to identify candidate sites for inclusion in the sentinel surveillance activity.

7. To what extent are the Global Program on AIDS impact indicators on STDs being collected and reported?

STDs are managed routinely within the primary care system, and formal health facility surveys to assess STD case management have not been conducted. Formal standards for STD assessment and treatment have recently been developed as part of the introduction of syndromic STD management, and will soon be distributed. Syndromic management will be pilot-tested in the four UMIETS before it is introduced at area health centers. It will be essential that the evaluation of syndromic STD management and of the four recently established UMIETS include specific health facility surveys that address the two GPA indicators for STD case management.

The assessment of STD and HIV prevalence in women has already been described as a part of sentinel surveillance. Aggregate results from syphilis screening of antenatal mothers (required by national policy at the first prenatal visit) are also reported by laboratories to each health region. However, the value of this data to assess STD prevalence indicators is limited because only 30-50% of pregnant women receive screening.

The indicator for history of urethritis in men was included in the recent national health survey; analysis of this survey is underway. Male urethritis has also been added to the weekly reports from health centers as a notifiable STD syndrome. However, this information is not routinely collected from IHSS clinics, where a large proportion of working males receive care.

8. To what extent is the syndromic approach to STDs being implemented in the STD clinics and health centers? How many persons have received training in this approach? To what extent have the clinics increased their coverage?

Substantial preparation to introduce syndromic STD management has been completed, and initial implementation is about to begin. A comprehensive manual for syndromic management has been drafted, and training for eight persons from the UMIETS in each of the four project health regions (Metropolitan, 2, 3, and 6) will commence August 25. These individuals will then train individuals from other health centers in each region. Specific schedules have not yet been developed for this training. Notably, providers from the IHSS health system in San Pedro Sula have not been included in the implementation of syndromic STD management. The UMIETS have just begun to provide services. Initially, each of the UMIETS will concentrate on STD management for commercial sex workers, many of whom currently attend health centers for weekly "control" visits.

Monitoring will be a major challenge for the project to ensure that the training and resources for syndromic management are effectively disseminated and widely adopted. While it is appropriate to gain experience during the early stages by starting at the UMIETS, HIV control through effective STD management is a community-level intervention, which must penetrate beyond specific target groups, especially to local settings where diagnostic resources are least available. Detailed plans need to be developed for the training and logistics necessary for widespread implementation of syndromic management. For example, the training in syndromic management requires a one-week commitment of personnel; this will require significant advance planning. Adequate supplies of the drugs necessary for syndromic management will need to be consistently available at CESAMOs. The abbreviated pocket version of the STD manual containing the flow diagrams for management needs to be completed for quick and easy reference.

Most emphasis so far has been placed on treating CSWs; much less has been devoted to reaching their clients. It is doubtful that STD and HIV transmission can be substantially reduced without concomitant efforts with male partners. However, women comprise the majority of patients seeking treatment for STD symptoms at health centers in all four regions. Especially in San Pedro Sula, males represent a large proportion of the clientele at IHSS facilities, but these facilities use different STD treatment guidelines, and have not been included in current programs for syndromic management, nor are the necessary drugs available through IHSS. It is frequently reported that many patients, especially males, receive treatment directly from pharmacies. It will be important to educate pharmacists and enlist their assistance in disseminating information about syndromic treatment algorithms.

9. To what extent have the STD clinics and labs in the project area been refurbished and equipped? Is there an adequate supply of appropriate drugs on hand in each clinic?

The patient areas in the four project area STD clinics have been completely refurbished and equipped. A designated laboratory is in place only at the Tegucigalpa clinic, and on-site laboratories are planned for the other three clinics. Each currently has ready access to the health center laboratory for phlebotomy, microscopy, and gram stain examinations. The Miguel Paz Barahona laboratory also performs gonorrhea cultures. Though reagents for syphilis testing are currently adequate, there has been a history of frequent shortages.

For treating discharges, spectinomycin was available in the clinics in Tegucigalpa, Comayagua, and La Ceiba. Procaine penicillin was the only drug available in San Pedro Sula. Supplies of the drugs necessary to implement syndromic STD management have been arranged from World Bank funds for 1996 and 1997, but these are not yet available in the clinics. Concern was voiced frequently about whether adequate supplies would remain available. It is not yet possible to predict utilization, nor assess the adequacy of current supplies.

10. To what extent have STD messages and referral systems been integrated into the People in the Work Place programs?

This program is in the early stages of implementation, it is not yet possible to assess this indicator. Training has been held for business managers, but few sessions have been held with workers. The MOH reports that training so far has been enthusiastically received, with indications of continued cooperation from businesses.

Dr. Ada Rivera, director of the Preventive Medicine program for IHSS in San Pedro Sula, voiced two specific concerns about these efforts. First, there is a need for educators with specific expertise. From past IHSS workplace initiatives, Dr. Rivera has experienced that the questions posed are often quite sophisticated, and may be difficult to answer for volunteers without extensive training. When educators were unable to answer such questions, business managers became skeptical and much less willing to devote employee time to the program. Second, some ministry efforts (through PETSIDA) may be duplicating efforts by targeting on the same companies that are IHSS affiliates and have already been the focus of IHSS interventions. Better coordination will be essential to maximize the number of companies participating in the program.

The issue of referral systems is an important area where the involvement of IHSS in San Pedro Sula needs to be improved. A large proportion of patients eligible for IHSS are concentrated in San Pedro Sula, and receive STD care either from IHSS or from company physicians. Although they represent an important group for extending project activities, these providers have not been actively involved in the enhancement of STD services nor syndromic STD management.

11. To what extent has the demand for, access to, availability, and use of condoms among the target populations increased? To what extent has the consistent and correct use of condoms been promoted?

All clinic sites reported that the demand for condoms is high, and supplies are sufficient to meet the demand. Recent changes in MOH policy has also allowed the clinics to supply as many condoms as requested to CSWs at each visit. In the past, distribution had been restricted to 30 condoms, when as many as 50 were often requested. Ample condom supplies were available at all clinics. Providers reported that consistent condom use is promoted with clients at each visit, and both pamphlets and models were available to demonstrate correct condom use. Drafts of the baseline KAP surveys indicate condoms are widely available, but condom use (and consistent use) is much less frequent, especially among women. It is too early in the project to detect whether condom use has increased.

12. To what extent are the MOH STD clinics working with the CSWs NGOs for referrals and counter referrals?

These activities have scarcely commenced, as NGOs have just recently completed their baseline surveys, and have not begun fully developed programs. The MOH STD clinics do not believe they have yet received referrals, and are under the impression that many CSWs who avail themselves of NGO services are not referred to clinics. This was of particular concern in San Pedro Sula, where both regional director Dr. Carlos Bennaton and STD/HIV coordinator Dr. Mirna Thiebaud Alvarenga expressed concern that the NGO role be clarified with respect to interactions with the STD clinic.

It will be important to ensure that resources are sufficient to meet the demand created by referrals. A description of clinic activities may help illustrate the potential problem. Traditionally, most CSWs attend STD clinics weekly for "control," representing 30-60 daily visits at each clinic. The CSW receives a carnet, a booklet in which the date of each visit is recorded and certified by seal. The patient is interviewed and examined for symptoms and a gonorrhea culture is taken. Blood samples are obtained for syphilis every three months, and HIV testing is recommended every six months. (Acceptance of HIV testing is variable; the San Pedro Sula and La Ceiba clinics report that most clients agree to testing, while in Tegucigalpa and Comayagua, the proportion who agree to testing is lower.) Condoms are provided at each visit, along with reinforcing messages about correct and consistent use. However, it is perceived that most of the CSWs attending control are "captivas," i.e., CSWs from brothels who are most compliant with control, and who may be at lower risk as they historically report high rates of condom use. Efforts to improve attendance by ambulantes, CSWs who work the streets, if successful, will substantially increase utilization by higher risk persons. However, It is doubtful that the clinics could effectively meet the demand for weekly visits by each client.

For several reasons, the requirement for weekly visits should be reconsidered. First, it may be most appropriate that efforts for referral concentrate on improving awareness of STD symptoms

and the need to seek treatment. Second, the control system presents somewhat of an ethical dilemma. While the system enhances opportunities to reach CSWs with prevention messages and to detect STDs, the carnet may be misinterpreted by clients as a clean bill of health, even though CSWs who test positive for HIV can still obtain weekly carnet certification.

13. What obstacles still exist for the delivery of STD diagnosis and treatment services to the target populations? How can these obstacles be overcome?

Enhanced systems for STD diagnosis and treatment are now being implemented. Most of these efforts have been focused on CSWs. An effective mechanism has not yet been developed to increase the coverage among CSWs not currently involved in control. For example, a group of women come into Comayagua each weekend, offering sex services to servicemen from the Pamerola base. These women do not consider themselves to be CSWs, and there has been little success in reaching them for services. Perhaps specific NGO activities can help to access groups such as these.

More importantly, there has been little progress made toward improving STD services for their clients, for men who have sex with men (MSM), nor for the Garífuna population. There is a general sense that the UMIETS were developed primarily for CSWs, to reduce stigma and to deliver integrated services such as women's health and even health care for their children. Although a small number of male CSWs receive services at the UMIETS in Tegucigalpa and San Pedro Sula, there appear to be few resources available for MSM or for men in general, and little effort to bring them into care. Men represent two-thirds of AIDS cases in Honduras, but women comprise the majority of those receiving care for STD symptoms at the CESAMOs.

Greater involvement and coordination with IHSS in San Pedro Sula is essential. IHSS provides health care for a significant proportion of working men through their clinics and hospital in Sanitary Region 3. Within IHSS itself, it appears that few resources have been made available to suggest that either enhanced STD care or HIV prevention in Region Norte represent a priority. IHSS is responsible for a large proportion of the population in this region, which includes San Pedro Sula and Progreso, and represents an area that has reported approximately half of all AIDS cases from Honduras, and where the highest seroprevalence rates in the country have been documented. Although a doctor has been assigned for an STD clinic planned at the hospital, the clinic has been neither equipped nor supplied, and the medications necessary for syndromic treatment are not available. Despite a large number of hospitalized AIDS cases and deaths, no infectious disease specialist is available at the hospital.

Data from the NGO baseline surveys and recent health survey for men may be useful to gain insight into where men currently receive health services, and to design mechanisms to increase their access for STD care. It is possible that the scope of the UMIETS could be expanded to deliver STD care for more men as well as women. However, it will also likely be necessary to

include private physicians and pharmacies in efforts to enhance STD treatment for men. Strategies for NGOs working with MSM and Garífuna must also include specific promotion of recognition of STD symptoms and the need to seek treatment.

14. Is further assistance, technical and/or material, in this area necessary, and if so, what type of assistance?

Several types of assistance may strengthen STD diagnosis and treatment services for the target population. As mentioned, greater coordination with IHSS is essential. As an initial step, materials to refurbish and equip the STD clinic at the hospital in San Pedro (analogous to those provided for the UMIETS) would develop an important resource to expand STD services.

Technical assistance to extend training in syndromic management should be continued. Support for additional personnel to perform training and monitoring may be required. There are a limited number of persons available in the UMIETS and Sanitary Regions. Since adequate training requires one week, it would appear that either the training or clinical services will suffer if currently available personnel are to train a sufficient number of persons in area health centers. An adequate supply of training materials, in particular the pocket guide with flow diagrams for syndromic management, must be available to supply providers in all health centers.

Assistance should also be provided with logistics management to ensure an adequate supply of the necessary medications are consistently available in the health centers.

Support for two additional studies may also help ensure that syndromic management of STDs succeeds in Honduras. First, skepticism remains about the adoption and sustainability of syndromic treatment. Ministry personnel ask for evidence that it has been successful elsewhere in Latin America. A study to validate the effectiveness (compared to the etiologic or clinical approaches) would generate benefits for Honduras and elsewhere. A cost-effectiveness analysis would also help to develop persuasive evidence that the syndromic approach is in fact able to achieve positive health outcomes and a reduction in disease at an affordable cost.

15. Is the surveillance of STDs and HIV necessary for monitoring the epidemic functioning well? How can this activity be strengthened?

Although the surveillance systems in Honduras have until now been among the best in Central America, it appears that the evidence that is currently generated may be misleading, and does not accurately reflect the epidemic. Although surveillance reports reflect extremely low levels of syphilis and gonorrhea, a study of commercial sex workers currently being conducted by Dr. Cesar Nuñez among commercial sex workers has found information that is quite contradictory. Preliminary results indicate a prevalence of 20% for syphilis, 12% for gonorrhea, and 9% for HIV. [These figures were provided by Dr. Mayté Paredes; the complete study was not available for review.] This suggests that neither the regional nor sentinel surveillance system accurately

reflects the STD burden and Honduras, and lends support to the suspicion that either current syphilis testing is not reliable, or the appropriate populations are not gaining access to screening programs. Strengthening of sentinel surveillance, as outlined earlier, may be the most efficient mechanism to more reliably assess STD indicators.

Several factors indicate that AIDS case reporting and HIV surveillance does not accurately reflect the status of the HIV epidemic in Honduras. The distribution of reported AIDS cases by year (Table 3) suggests a reduction in the annual number of cases since 1993. However, reports from hospitals suggest an increasing burden. There may be several reasons for this discrepancy.

Table 5: Distribution of Reported AIDS Cases in Honduras, by Year		
Year	No. of Cases	% of Total
1989	260	4.9
1990	605	11.4
1991	514	9.7
1992	752	14.2
1993	974	18.4
1994	867	16.4
1995	850	16.1

1. Misclassification in the HIV Case Reporting System. AIDS cases are reported on the *ficha* accompanying the request for the HIV blood test at the time of first testing. On this form, the patient is classified into one of three categories, according to symptoms present at the time of testing: AIDS (meeting the Caracas case definition), AIDS-related complex (ARC), or an asymptomatic carrier. As there is no subsequent clinical case report, there is no mechanism to update this classification. That is, once a patient is classified as asymptomatic or ARC, this classification remains in the system, even though the patient subsequently develops AIDS. This results in a significant underestimation of AIDS, even among reported cases. Through May 1996, there have been 1,014 cases reported as ARC and 1,765 reported as asymptomatic carriers. It is not possible to determine how many of these reflect AIDS cases that have not been reclassified. It appears, however, that as testing has become more available, and an increasing number of persons are tested earlier in their course of HIV disease, and are not classified as AIDS.

Of note, Honduras has employed a reporting system using patient names. San Pedro Sula is considering the use of a code reporting system, in lieu of names for Sanitary Region 3. The proposed code system presents several disadvantages, in that the code is not unique, and the likelihood of duplicate and inaccurate reports is high. Unless there is a compelling reason to move to this code system, it does not appear warranted.

2. **Under reporting of identified HIV positive persons.** Case reports using the *ficha* are generated only for patients tested in MOH or IHSS laboratories. Other testing sources are much less likely to report. For example, in addition to blood donors, the Honduras Red Cross provides fee-for-service testing for patients with a doctor's order, and identifies 230-280 persons positive for HIV each year. The number (though not names) of HIV positive blood donors are reported to the MOH, but the Red Cross does not report these other patients who test HIV positive, assuming that they would be reported by the doctor ordering the test. There does not appear to be a mechanism to do so, and such reporting happens infrequently.

3. **Lack of testing.** Although HIV testing is widely available, there appear to be many reasons for persons to avoid voluntary testing: little early treatment is available, HIV positive persons face substantial discrimination in employment and in the community, and support systems for HIV infected persons are not well developed. The high HIV prevalence among persons tested voluntarily (Table 4) suggests that only persons with symptoms or at highest risk seek testing.

Table 6: Voluntary HIV Test Results, General Population, Honduras			
Year	Persons Tested	No. HIV+	% HIV+
1989	4,987	496	10
1990	8,477	1,003	12
1991	10,841	2,406	22
1992	13,905	1,251	18
1993	14,047	2,153	15
1994	12,877	2,379	18
1995	12,853	1,360	10

Given these circumstances, it is difficult to determine the actual status of the epidemic. Blood donor screening can be used to give some general indication of HIV prevalence among the general population. The use reduction in seroprevalence after the introduction of donor deferral questionnaires after 1989 suggests that persons at high risk for HIV are excluded from this

population. Despite this fact, HIV prevalence has remained consistently high in blood donors recruited both by hospitals and by the Red Cross. The highest HIV prevalence among volunteer blood donors has been observed in San Pedro Sula, hovering around 1% (Table 5).

Table 7: HIV Prevalence (%) Among Blood Donors, Honduras			
Year	Hospital Donors	Red Cross Tegucigalpa	Red Cross San Pedro Sula
1990	0.34	0.60	1.68
1991	0.40	0.20	1.20
1992	0.60	0.25	0.80
1993	0.65	0.47	0.98
1994	0.75	0.31	0.73
1995	0.56	0.27	0.56

The inferences that can be drawn from available data suggest that HIV infection continues to be well established in the Honduran population. Although there is no evidence of an explosive increase, there is also none to suggest that prevalence is subsiding. Importantly, there are few data from persons at highest risk, and virtually none among MSM.

Additionally, information on risk factors for transmission may not be reliable. This information is collected at the time blood is drawn, and additional information obtained when persons are counseled at the time they receive positive test results is not reflected in case reports. Studies in other countries have shown that risk factors other than heterosexual transmission are often identified during subsequent interviews.

Several options exist for monitoring the progress of the epidemic:

1. **Sentinel Surveillance.** Recommendations have already been made (question 1) for strengthening sentinel surveillance in pregnant women and CSWs. In addition, there may be opportunities to develop sentinel information among men. Currently, syphilis testing is required in order to obtain a certificate of health before employment. This might represent a source for unlinked anonymous HIV prevalence surveys among men and women in their sexually active years.

2. **Targeted seroprevalence surveys** in specific populations may be helpful in guiding prevention efforts. Specifically, little reliable information is available among MSM and the Garífuna population to determine the extent of the epidemic in these high priority groups.

3. **Case Investigations.** It is likely not practical to reinvestigate the persons who have been reported as asymptomatic or ARC to determine their status. Although this could better define the actual number of cases, it would be difficult to justify the necessary expenditure of effort and resources without a specific justification, as it would likely provide little information on where the HIV epidemic is moving in Honduras. However, a more careful interview of recently diagnosed cases by trained counselors may help to provide more accurate information about how and where HIV is spreading. Such interviews could develop more detailed information on sexual histories, possible contacts, travel, etc., and potentially guide subsequent prevention efforts. Many of these interviews already take place during post-test counseling, but the information is not collected in a systematic fashion.

4. **Clinical Case Reporting.** It would be prudent to initiate a system of clinical case reporting, whereby hospitals and physicians would report persons who present with symptomatic AIDS, regardless of when or where they were first tested for HIV. This would help to develop more accurate information on AIDS incidence in the future. As Honduras uses a system of name reporting, duplicate case reports could be avoided by using an adequate data system.

It is likely that a combination of these methods will be necessary to provide sufficient information for planning, resource allocation, and for the design and monitoring of interventions.

NGO Specialist

16. To what extent have the project-supported NGOs been strengthened administratively and technically?

There is a general consensus at the IAs that AIDSCAP's intensive training managed, in a very brief time, to provide each institution with basic project development and accounting skills, including an in-depth review of the original proposals, the use of a logframe, Gantt charts, designing evaluation and follow-up plans, and how to prepare a detailed budget. All IAs recognized that their administration skills were strengthened by this training, and for many of them, this was the first time that they had accounting guidelines. However, the rapid implementation of the project produced several complaints.

Among these are:

1. The administrative and accounting formats appeared too complicated. However, once these tools were learned and understood, the IAs felt more at ease with them, mainly because they had received extensive counseling by phone or in person from AIDSCAP. Identified by all IAs.
2. The overlap of two distinct administrative systems provoked a negative response from the administrative personnel at the Honduran Social Security Institute (IHSS) that saw the project as requiring two accounting systems, one for USAID, and one for IHSS.
3. The decision to purchase equipment abroad, and the equipment and software decisions themselves resulted in problems caused by the delays in shipping, poor quality of the equipment purchased, the fact that there were no useable warranties or maintenance policies, and absence of anti-virus software. Identified by all IAs.
4. Lack of information for the design of focus group research, and the short turn-around for the presentation of these results. Identified by the IHSS.
5. Although AIDSCAP's assistance to the projects is timely, it is used more to review than to assist the work process. Field work was not closely monitored, and problems with the conduct of the research were not identified until too late. Identified by most IAs.
6. Training in Tegucigalpa for the IAs on the North Coast, and training on weekends, required travel days, weekends, and great expense. For the national institutions involved this means overtime pay, and lost travel weekdays. Identified by ODECO, CGS, IHSS.
7. Absence of AIDSCAP personnel based in the regions that have the majority of projects (3 and 6). Identified by ODECO, CGS, IHSS.

8. In the projects that involve sex workers, the lack of specific training or strategies to reach clients. Also several IAs expressed interest in training in areas such as masculine sexuality and group dynamics. Identified by PRODIM, CEDEPS, FSLs, UMIETS, COCSIDA.

9. Difficulties in managing topics such as bisexuality and homosexuality. Identified by CGS, UMIETS, CEDEPS, COCSIDA, FSLs.

10. Some of the consultants sent by AIDSCAP were perceived as overstepping their role as consultant to the NGOs, "they lack tact, and they do not know the role of a consultant." Identified by IHSS.

11. Problems experienced with the conduct of the survey research. Identified by all IAs:

- a) Salaries used for budgeting were effectively devalued by currency changes, which has resulted in diminished earnings for the contracted staff and IA personnel;
- b) Difference in salaries received in the private and public sector. Public sector salaries are significantly lower, are not competitive, and the difference can create friction in working groups.
- c) Lack of clear work plans or guidelines for the survey activity at the proposal stage meant that many projects were understaffed.

12. Problems of maintaining and conserving condoms in optimum condition due to the lack of air conditioners, or appropriate areas for their storage. Identified by IHSS, CGS.

13. Lack of equipment in CGS's project to carry out their educational task: their initial request for an overhead projector, a slide projector, screen and photocopier was denied. They also feel they need a second telephone line, given the large number of calls they receive daily on their hot line.

14. Lack of transportation to the work sites, especially in projects that have volunteers or unpaid personnel that need to travel and have no vehicles of their own. Identified by UMIETS, CGS, ODECO, IHSS.

15. Limited access to information resources, documentation, and updated training necessary to provide high quality information and education in subject matter that they manage. Identified by all IAs.

Complaints arose because of differential treatment of the IAs. Although AIDSCAP cannot purchase vehicles, one was repaired. Identified by CGS, ODECO.

Although not all of these complaints can be taken seriously they demonstrate the sense of sibling-like competition among the NGOs, the special sensitivity of CGS, and issues of on-site support.

17. To what extent have the project NGS established working relationships with their target populations (CSWs, PWP, the Garífuna and MSM)?

All teams have established a working relationship with their target populations, although the quality and nature of the relationship varies greatly from one IA to another.

The NGOs identified as having greater knowledge of their target populations are CGS, FSLs, ODECO and COCSIDA. Institutionally, the MOH (UMIETS), COMVIDA and IHSS have better defined that working relationship. PRODIM and CEDEPS are beginning their activities with their target populations.

Interviews indicate that the knowledge of the target population does not necessarily imply that the working relationships are the most appropriate. Factors that indicate more clearly the depth of understanding of the communities where they are working can be summarized in two key concepts: target group involvement and participation in the design and implementation, and the authorization of key figures in each community.

Involvement. Almost none of the IAs were directly involved with target audience members in the development of their proposals, with the exception of CGS.

Therefore, almost all of the organizations and institutions involved adopted a top-down approach, which is sometimes perceived as coercive. For example, CSWs were offered free medical services for their children if they participated by COMVIDA, PRODIM, CEDEPS, COCSIDA.

These strategies of pressure and rewards, in the midterm and even in the short term, risk generating an undesired dependency, and could provoke desertion of these target populations when, for any reason, the IAs become unable to provide these "rewards."

Participation. The use of terms such as "participating," "workshops," and "training" to explain the means in which they are working with target populations, is overused, and is associated in many projects with methodologies that are not participatory. Many interactions are more like typical school lessons, or lectures—which are sometimes tedious due to the high technical language used. Some IAs show films to hook an audience for follow-up discussions—even though these films have nothing to do with the subject. Many use questionnaires that are boring, and tiring for the audience. All IAs.

An area in which participation begins to take shape is the elaboration of materials, but here also, only in a utilitarian way—many IAs use those who attend to validate the materials. PRODIM, COCSIDA, CEDEPS, FSLs.

This strategy does not generate ideas from the community, but simply asks them to respond. There is the risk of bringing ideas, proposals, messages, images, and solutions from outside of the communities. We have yet to explore what the results and impact of this type of work with the target communities will be, and if these results are the ones behind the achievement of the project indicators.

Authorization. Another element to understand how the IAs work with the target communities is through the understanding the term, "education among equals" that is used in almost all the projects. All the work aimed towards the CSWs mention that they will identify leaders in the community, who in turn will become peer educators. This often creates resentment, though, since CSWs state that they would prefer to get their information from other sources, such as health educators or nurses. Almost all IAs.

Examples provided by IAs that work with this theme indicate that the identification of women leaders among the CSWs, due to their intelligence, interest, sympathy, strength or violence has produced a contrary effect—the rejection of their equals. "What can that whore teach me, if she is like me!" was frequently expressed. The possibility exists that they get disenchanted with the project, or, in extreme cases, attack the "peer" "leader." PRODIM, COCSIDA, CEDEPS, FSLs.

The above example indicates that the IAs need to expand the knowledge of their target population, and the nature of the educational and persuasion tools with which they are working and their development.

Except for the FSLs, none of the projects are working directly with persons who live with HIV or AIDS. The inclusion of these actors is indispensable to better understand the perspectives of those directly affected, and integrating them into the sensitivity and training strategies.

18. To what extent have the NGOs been successful in increasing the perception of risk of HIV infection among their target populations and decreasing their high-risk sexual behavior?

Most of the projects have yet to formally begin the planned interventions. However, some of them have already completed field work and have begun working with groups, or getting closer to their public, which makes it impossible to evaluate these requirements, both in the increase of the perception of risk, as well as the change of high-risk behaviors with the resulting use of condoms or practice of safe sex.

A theme of great importance for all projects has to do with the change of behavior. Research with those interviewed indicate that it is not yet clear to them which would be the appropriate

methodologies so that their target populations consider, first of all, the need to change; second, how to promote those changes; and third, how to sustain them.

Several expressed confusion in what they are trying to achieve when they refer to changing behavior, since it is not clear if their goal is a change of practices and not necessarily of conduct (a man or woman with multiple partners can practice sex with a condom, change the practice, and continues having multiple partners, retains the behavior); life styles as well as practices ("take out" a sex worker from that activity, which leads to her abstaining from sex with several men and does it only with one, and uses a condom); or orientation, that they see as the same as change in behavior: that homosexuals stop being so. Most IAs.

Examples that the information provided by IA educators (focused mainly in lecturing, moral exhortation, fear or guilt, expressed sometimes as "responsibility") has led to the successful change of behavior of "intervened" persons (a CSW has "stop working," she was homosexual, but "fortunately she heard God and paid heed"), suggest that there is a conceptual confusion which is necessary to address. Most IAs.

19. To what extent are the project NGOs coordinating with the MOH and with each other in the health regions where they work?

According to interviews with all of the NGOs, coordination and relations among them have improved substantially, taking as reference the situation they were in 12 months ago.

During the field visits, the IAs expressed a desire to establish a coordination with AIDSCAP with different dynamics to those promoted to date.

CGS has expressed frustration because it believes it is the "most unjustly watched over IA", both by AIDSCAP and the MOH—who they blame for the drastic reduction of their initial budget, which they claim was not as severe with the other IAs—as well as by the Municipality (who has requested "to implement their project as silently as possible"). CGS claims there is a latent homophobia in the excessive control that they feel is put on them, which in practice may result in paralyzing the project.

Concerning the need for AIDSCAP to coordinate the requests for assistance, visits, advice, etc., by the IAs, they mentioned that, regardless of AIDSCAP's good intentions, especially on the part of their Director, Dr. Higuero, they perceive a need in AIDSCAP for additional personnel whose specific task would be personalized attention to each IA.

Another area that needs better coordination is the one involved with the sustained exchange of information, experiences or activities among the IAs themselves, whether at regional or area levels. The newness of the project and the work overload they perceive explains this need. Few people within each team know what the other IAs do, and the need to find mechanisms for the exchange of information, experiences, materials, etc., was expressed. Even though the IAs have

shared some time together, this was in the context of accelerated work, which allowed little time for more personalized and mutual knowledge, for shared reflections, for the exchange of information and experiences which several IAs have identified as necessary.

None of the IAs, with the exception of the MOH, have executive summaries of all the projects, nor do they know about the advances, obstacles, and solutions to problems identified during the CCAP surveys. It is unknown what other IAs did during their investigation, since they took to heart the admonition for confidentiality expressed by AIDSCAP. The spirit of the "AIDSCAP family," with which several IAs expressed in identifying themselves, may in practice be vulnerable if the isolation problem between the IA teams is not dealt with strategically.

20. What potential exists for the continuation of NGO activities after the termination of project financial support? What other potential sources of NGO funding are there?

All IAs expressed their wish to sustain their projects beyond the financial assistance provided by AIDSCAP, through their own means, or with the assistance of other agencies, local and national which represent a clear commitment on their part. The feasibility of these projects, or others related with HIV and STDs, and their capacity to continue in the future, goes beyond good intentions, and has to do with the quality and appropriateness of training, with the satisfaction and the ability to reach the goals planned in the projects under "normal" work conditions—i.e., without the continuous pressure to comply with the planned and numbered goals—and with the solid theoretical, technical, organizational and administrative knowledge of the IAs.

The possible inclusion of new actors (FUDENA), the risk of losing some on the way, (like OFRANEH) the risk that other groups like the CGS may stop functioning (not for the lack of will, capacity, or vision, but because of administrative reasons like the difficulty of obtaining their legal identity), are elements that make AIDSCAP and USAID's challenge difficult in Honduras, and requires innovative answers.

In the specific case of CGS, which is the only project working with the homosexual population, it is important to provide it with assistance to obtain their legal identity, since if they do not achieve this, the continuation of their project is doubtful. It was suggested to CGS that they drop the word gay from their name to facilitate the legal identity.

All IAs must design strategies that ensure concurrent financing and/or complementary financing and receive extensive technical assistance, to allow the IAs to increase their capacity to reach their goals.

Technical assistance should be directed to helping the IAs to: increase the perception of risk in their target population; how to consult with their communities to ensure and sustain changes in behavior process; how to explore in-depth sexuality and sexual health; how to adopt a gender focus that includes masculinity as an essential theme; generalized training in the areas of STDs symptoms; and how to include of persons who live with HIV/AIDS in the work of the IAs.

21. What further NGO support will be necessary from September 1997 through September 1999?

Necessary projects identified by the IAs throughout the interviews may be summarized as follows:

- a) Training the IAs in the search for resources, through the provision of directories of financing agencies interested in donating funds to Honduras, and of exercises accompanied by the elaboration of simple proposals that complement the work done by IAs.
- b) Close follow-up of AIDSCAP with the IAs to adequately support them in the process of involving members of the target communities in the design, planning, and implementation programs;
- c) Support in accessing non-financial resources—documentation, information, training and increase of skills—that strengthen the capacity of the IAs and that will motivate them to promote a shared platform on the vision and understanding of the epidemic.
- d) Continued support to the IAs so that they sustain their achievements in the areas of perception of risk, changes in behavior, access to treatment in STDs, and use of condoms through a closer, not coercive- follow up; and the provision of techniques and appropriate skills for the prompt solution of problems.
- e) Support, training, and funding to establish an electronic communication network between the IAs and AIDSCAP to expedite information and rationalize resources.
- f) Exploring ways in which AIDSCAP can obtain collaboration from PASCA for the IAs.
- g) Identify and include in the training process other organizations that are currently working in HIV and who had no access to financing, for instance, the Asociación de Mujeres de Lucha Contra el SIDA.

Other recommendations:

- 1. Include a line item in the budget for maintenance of equipment donated by AIDSCAP to the different projects.
- 2. Review salaries, making adjustments according to the program's financial situation and the existing inflation.
- 3. Complete the equipment requirements to support education initially petitioned by CGS-Project for Men.

4. Authorize the acquisition of air conditioning equipment for the IHSS and CGS.
5. Review the possibility of increasing the transportation allocation to support the mobilization of volunteer educators to their places of work in the different projects.
6. Review the possibility of expanding the target populations and induce youth to one of them.
7. Contract two additional persons at the NO to assist the northern regions (SPS and La Ceiba), where most projects are concentrated.
8. Review the possibility to authorize the contracting of educators and/or additional personnel in various projects (CGS, ODECO, IHSS).

Annex 2
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